BEFORE THE BOARD OF PODIATRY

STATE OF IDAHO

In the Matter of the License of:	)	
	)	
STEPHEN A. ISHAM, D.P.M., License No. P-76,	)	Case No. POD-P4B-01-98-004
	)	
	)	**STIPULATION AND**
Respondent.	)	**CONSENT ORDER**
	)	

POD\p6079lmc.doc

WHEREAS, information having been received by the Idaho State Board of Podiatry (hereinafter the "Board") which constitutes sufficient grounds for the initiation of an administrative action against Stephen A. Isham, D.P.M. (hereinafter "Respondent"); and

WHEREAS, the parties mutually agree to settle the matter pending administrative Board action in an expeditious manner; now, therefore,

IT IS HEREBY STIPULATED AND AGREED between the undersigned parties that this matter shall be settled and resolved upon the following terms:

A.

1. The Board may regulate the practice of podiatry in the State of Idaho in accordance with title 54, chapter 6, Idaho Code.

2. Respondent Stephen A. Isham, D.P.M. is a licensee of the Idaho State Board of Podiatry and holds License No. P-76 to practice podiatry in the State of Idaho. Respondent's license is subject to the provisions of title 54, chapter 6, Idaho Code.

COUNT ONE
Washington Podiatric Medical Board
Docket No. 98-06-A-1074PO

3. On or about March 14, 2002, the State of Washington Department of Health, Podiatric Medical Board entered a Findings of Fact, Conclusions of Law, and Final Order in In the Matter of the License to Practice as a Podiatric Physician and

Surgeon of: Stephen A. Isham, D.P.M., Docket No. 98-06-A-1074PO. A copy of the Findings of Fact, Conclusions of Law, and Final Order is attached hereto as Exhibit A.

4. In the Findings of Fact, Conclusions of Law, and Final Order, the Washington Podiatric Medical Board found that:

a. Respondent failed to conduct and document an appropriate pre-operative assessment of Patient A, in violation of RCW 18.130.180(4) and WAC 246-922-260;

b. Respondent failed to respond and intervene in a timely fashion which resulted in Patient A developing infection, gangrene and, ultimately, the loss of two of his toes, in violation of RCW 18.130.180(4);

c. Respondent failed to appropriately document the volume of Sarapin used on Patient B in Patient B's medical records, failed to document the number of injections, and failed to document the placement of the injections administered to Patient B, in violation of RCW 18.130.180(4) and (7) and WAC 246-922-260; and

d. Respondent failed to meet the standard of care by his decision to proceed with pharmacological intervention with Patient B, in violation of RCW 18.130.180(4).

5. In the Findings of Fact, Conclusions of Law, and Final Order, the Washington Podiatric Medical Board ordered that:

a. Respondent complete additional training in the areas of vascular assessment, wound care, and infection control;

b. Respondent prepare an article for publication in a journal regarding appropriate recognition and management of post-operative complications and infections resulting from minimally invasive surgery techniques following his completion of the additional training; and

c. Respondent pay an administrative fine of $15,000.

COUNT TWO
Washington Podiatric Medical Board
Docket No. 99-07-A-1035PO

6. On or about February 1, 2000, the State of Washington Department of Health, Podiatric Medical Board entered a Second Revised Findings of Fact, Conclusions of Law, and Final Order in In the Matter of the License to Practice as a Podiatric Physician and Surgeon of: Stephen A. Isham, D.P.M., Docket No. 99-07-A-1035PO. A copy of the Second Revised Findings of Fact, Conclusions of Law, and Final Order is attached hereto as Exhibit B.

7. In the Second Revised Findings of Fact, Conclusions of Law, and Final Order, the Washington Podiatric Medical Board found that:

a. Respondent utilized an experimental laser device on his patients, in violation of 21 C.F.R. pt. 812 and RCW 18.130.180(7);

b. Respondent failed to obtain informed consent as to Patient Gadd, in violation of RCW 18.130.180(4) and (13);

c. Respondent failed to adequately inform Patient Winship of the nature of a surgery and possible complications, failed to consider the patient's circumstances in his assessment of those risks, failed to advise the patient of the complications that had occurred, and failed to adjust his treatment plan in the face of clear evidence of a poor surgical result, constituting negligence and malpractice, in violation of RCW 18.130.180(4); and

d. Respondent failed to verify Patient Gushalak's ability to understand instructions given her and to consult with her caregivers to assure she would receive proper post-operative care, in violation of RCW 18.130.180(4), and failed to fulfill his professional obligation to inform Patient Gushalak or her caregivers about the nature of surgery she was to undergo or the risks of the surgery and its necessary post-operative care, in violation of RCW 18.130.180(13).

8. In the Second Revised Findings of Fact, Conclusions of Law, and Final Order, the Washington Podiatric Medical Board ordered that Respondent's Washington license be suspended for five years, stayed subject to the following conditions, among others:

a. Respondent shall refund all fees paid by Patient Winship or her insurance company for the second surgery;

b. Respondent shall pay an administrative fine of $21,000;

c. Respondent shall complete two, one-week courses at the Podiatric Foundation in Tucker, Georgia;

d. Respondent shall obtain written second opinions from a Board-approved qualified practitioner prior to all metatarsal osteotomies; and

e. Respondent shall quarterly submit to the Board a list of all surgical procedures he performs.

9. On or about February 21, 2002, the Second Revised Findings of Fact, Conclusions of Law, and Final Order was affirmed by the Superior Court for the State of Washington, in and for the County of Spokane, in Isham v. State of Washington Department of Health, Podiatric Medical Board, Case No. 01203857-0. A copy of the Superior Court's Findings of Fact, Conclusions of Law and Order is attached hereto as Exhibit C.

10. The Findings of Fact, Conclusions of Law, and Final Order entered by the Washington Podiatric Medical Board in Docket No. 98-06-A-1074PO and the Second Revised Findings of Fact, Conclusions of Law, and Final Order entered by the Washington Podiatric Medical Board in Docket No. 99-07-A-1035PO constitute grounds for disciplinary action against Respondent's license to practice podiatry in the State of Idaho pursuant to Idaho Code § 54-608(5) and IDAPA 24.11.01.500.

11. Respondent, in lieu of proceeding with a formal disciplinary action to adjudicate the allegations as set forth above, hereby agrees to the discipline against his license as set forth in Section C below.

B.

I, Stephen A. Isham, by affixing my signature hereto, acknowledge that:

1. I have read the allegations pending before the Board, as stated above in section A. I further understand that these allegations constitute cause for disciplinary action upon my license to practice podiatry in the State of Idaho.

2. I understand that I have the right to a full and complete hearing; the right to confront and cross-examine witnesses; the right to present evidence or to call witnesses, or to so testify myself; the right to reconsideration; the right to appeal; and all rights accorded by the Administrative Procedure Act of the State of Idaho and the laws and rules governing the practice of podiatry in the State of Idaho. I hereby freely and voluntarily waive these rights in order to enter into this stipulation as a resolution of the pending allegations.

3. I understand that in signing this consent order I am enabling the Board to impose disciplinary action upon my license without further process.

C.

Based upon the foregoing stipulation, it is agreed that the Board may issue a decision and order upon this stipulation whereby:

1. Respondent shall pay to the Board an administrative fine in the amount of Two Thousand and No/100 Dollars ($2,000.00) within thirty (30) days of the entry of the Board's Order.

2. Respondent shall pay investigative costs and attorney fees in the amount of One Thousand and No/100 Dollars ($1,000.00) within thirty (30) days of the entry of the Board's Order.

3. Respondent's License No. P-76 shall be placed on probation for a period of two (2) years. The 2-year probationary period shall begin the date of entry of the Board's Order. The conditions of probation are as follows:

a. Respondent shall comply within the next six months with all conditions set forth by the Washington Podiatric Medical Board in the March 14, 2002, Findings of Fact, Conclusions of Law, and Final Order in Docket No. 98-06-A-1074PO and the February 1, 2000, Second Revised Findings of Fact, Conclusions of Law, and Final Order in Docket No. 99-07-A-1035PO. The Board will accept the education credits Respondent has obtained.

b. Respondent shall comply with all state, federal and local laws, rules and regulations governing the practice of podiatry in the State of Idaho.

c. Respondent shall inform the Board in writing of any change of place of practice or place of business within 15 days of such change.

d. In the event Respondent should leave Idaho to reside or to practice outside of the state, Respondent must provide written notification to the Board of the dates of departure, address of intended residence or place of business, and indicate whether Respondent intends to return. Periods of residency or practice outside of Idaho will not apply to the reduction of the probationary period or excuse compliance with the terms of this Stipulation.

e. Respondent shall fully cooperate with the Board and its agents, and submit any documents or other information within a reasonable time after a request is made for such documents or information.

f. Respondent shall make all files, records, correspondence or other documents available immediately upon the demand of any member of the Board's staff or its agents.

4. At the conclusion of the two-year probationary period, Respondent may request from the Board reinstatement of License No. P-76 without further restriction.

Any request for reinstatement must be accompanied by written proof of compliance with the terms of this Stipulation. The Board retains discretion to grant reinstatement of Respondent's podiatry license or to deny reinstatement and continue the period of probation.

5. All costs associated with compliance with the terms of this Stipulation are the sole responsibility of Respondent.

6. The violation of any of the terms of this Stipulation by Respondent will warrant further Board action. The Board therefore retains jurisdiction over this proceeding until all matters are finally resolved as set forth in this Stipulation.

D.

1. It is hereby agreed between the parties that this Stipulation shall be presented to the Board with a recommendation for approval from the Deputy Attorney General responsible for prosecution before the Board at the next regularly scheduled meeting of the Board.

2. Respondent understands that the Board is free to accept, modify with Respondent's approval, or reject this Stipulation, and if rejected by the Board, a formal complaint may be filed against Respondent. Respondent hereby agrees to waive any right Respondent may have to challenge the impartiality of the Board to hear the disciplinary complaint if, after review by the Board, this Stipulation is rejected.

3. If the Stipulation is not accepted by the Board, it shall be regarded as null and void. Admissions by Respondent in the Stipulation will not be regarded as evidence against Respondent at the subsequent disciplinary hearing.

4. The Consent Order shall not become effective until it has been approved by a majority of the Board and endorsed by a representative member of the Board.

5. Any failure on the part of Respondent to timely and completely comply with any term or condition herein shall be deemed a default.

6. Any default of this Stipulation and Consent Order shall be considered a violation of Idaho Code § 54-608. If Respondent violates or fails to comply with this Stipulation and Consent Order, the Board may impose additional discipline pursuant to the following procedure:

a. The Chief of the Bureau of Occupational Licenses shall schedule a hearing before the Board. Within twenty-one (21) days after the notice of hearing and charges is served, Respondent shall submit a response to the allegations. If Respondent does not submit a timely response to the Board, the allegations will be deemed admitted.

b. At the hearing before the Board upon default, the Board and Respondent may submit affidavits made on personal knowledge and argument based upon the record in support of their positions. Unless otherwise ordered by the Board, the evidentiary record before the Board shall be limited to such affidavits and this Stipulation and Consent Order. Respondent waives a hearing before the Board on the facts and substantive matters related to the violations described in Section A, and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

c. At the hearing, the Board will determine whether to impose additional disciplinary action, which may include conditions or limitations upon Respondent's practice or suspension or revocation of Respondent's license.

7. The Board shall have the right to make full disclosure of this Stipulation and Consent Order and the underlying facts relating hereto to any state, agency or individual requesting information subject to any applicable provisions of the Idaho Public Records Act, Idaho Code §§ 9-337-50.

8. This Stipulation and Consent Order contains the entire agreement between the parties, and Respondent is not relying on any other agreement or representation of any kind, verbal or otherwise.

I have read the above stipulation fully and have had the opportunity to discuss it with legal counsel. I understand that by its terms I will be waiving certain rights accorded me under Idaho law. I understand that the Board may either approve this stipulation as proposed, approve it subject to specified changes, or reject it. I understand that, if approved as proposed, the Board will issue an Order on this stipulation according to the aforementioned terms, and I hereby agree to the above stipulation for settlement. I understand that if the Board approves this stipulation subject to changes, and the changes are acceptable to me, the stipulation will take effect and an order modifying the terms of the stipulation will be issued. If the changes are unacceptable to me or the Board rejects this stipulation, it will be of no effect.

DATED this 1 day of May, 2006. mjb for SAI

Stephen A. Isham
Respondent

I concur in this stipulation and order.

DATED this 3rd day of May, 2006.

NEVIN, BENJAMIN & MCKAY, LLP

By
Michael J. Bartlett
Attorney for Respondent

I concur in this stipulation and order.

DATED this 24th day of March, 2006.

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By
Emily A. Mac Master
Deputy Attorney General

ORDER

Pursuant to Idaho Code § 54-605, the foregoing is adopted as the decision of the Board of Podiatry in this matter and shall be effective on the 11th day of May, 2006. **IT IS SO ORDERED.**

IDAHO STATE BOARD
OF PODIATRY

By _____
Scott Graviet, Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 11th day of May, 2006, I caused to be served a true and correct copy of the foregoing by the following method to:

Dr. Stephen A. Isham
101 Ironwood Drive, Suite 131
Coeur d'Alene, ID 83814

- [x] U.S. Mail
- [ ] Hand Delivery
- [ ] Certified Mail, Return Receipt Requested
- [ ] Overnight Mail
- [ ] Facsimile: _____
- [ ] Statehouse Mail

Michael J. Bartlett, Esq.
NEVIN, BENJAMIN & MCKAY, LLP
P.O. Box 2772
Boise, ID

- [x] U.S. Mail
- [ ] Hand Delivery
- [ ] Certified Mail, Return Receipt Requested
- [ ] Overnight Mail
- [ ] Facsimile: _____
- [ ] Statehouse Mail

Emily A. Mac Master, DAG
Office of Attorney General
Civil Litigation Division
P.O. Box 83720
Boise, ID 83720-0010

- [ ] U.S. Mail
- [ ] Hand Delivery
- [ ] Certified Mail, Return Receipt Requested
- [ ] Overnight Mail
- [ ] Facsimile: _____
- [x] Statehouse Mail

Rayola Jacobsen, Chief
Bureau of Occupational Licenses

COPY

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PODIATRIC MEDICAL BOARD

In the Matter of the License to Practice as a Podiatric Physician and Surgeon of:	)	Docket No. 98-06-A-1074PO
STEPHEN A. ISHAM, D.P.M., License No. PO00000185, Respondent.	)	FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

A hearing was held before the Podiatric Medical Board (the Board) and Health Law Judge Kelly Theriot LeBlanc, Presiding Officer for the Board, on February 6 and 7, 2002, at the Holiday Inn, 17338 International Blvd., Seattle, Washington. Members of the Board present and considering the matter were: Panel Chair, William Ith, Public Member; John H. McCord, D.P.M.; David M. Bernstein, D.P.M.; and Stephen J. Stepanek, D.P.M., pro tem member. Jim McLaughlin, Assistant Attorney General (AAG), represented the Department of Health (the Department). Timothy Fennessey, Attorney at Law, represented Stephen Isham, D.P.M., (the Respondent). Robert H. Lewis, Certified Court Reporter, recorded the proceedings on February 6, 2002, and Duane Lodell, Certified Court Reporter, recorded the proceedings on February 7, 2002.

I. PROCEDURAL HISTORY

1.1 A Statement of Charges was issued on August 3, 1999, alleging that the Respondent, had committed acts of unprofessional conduct in violation of specified subsections of RCW 18.130.180. An Amended Statement of Charges was

subsequently filed on February 13, 2001, alleging violations of RCW 18.130.180 (4) (7) and WAC 246-922-260. The Board's deliberation and terms of this Order are limited to the allegations contained in the Amended Statement of Charges.

Exhibit A
Page 1 of 15

1.2 Respondent's Answer to the Amended Statement of Charges was filed March 15, 2001.

1.3 On April 6, 2001, the Adjudicative Clerk Office served the Third Amended Scheduling Order and Notice of Hearing setting this matter for hearing August 8-10, 2001. The discovery deadline and prehearing conference were set for July 13, 2001.

1.4 Prior to service of the Amended Statement of Charges, the Presiding Officer had issued seven Prehearing Orders. Reference to those Orders is purposely omitted other than to state that a previously scheduled status conference was convened on April 11, 2001. At that time, the Presiding Officer issued Prehearing Order No. 8, in which he indicated that the discovery deadline, motion deadline, prehearing conference, and hearing date remain STRICKEN. In this Order, the Presiding Officer also continued the status conference to May 14, 2001. A status conference was held on May 14, 2001, at which time a prehearing conference was set for July 25, 2001, without Order.

1.5 On July 25, 2001, following prehearing conference, the Presiding Officer issued Prehearing Order No. 9, re-establishing a discovery deadline and motion deadline for Respondent of August 10, 2001. The Department was given until August 24, 2001, to respond, after which Respondent was given until August 31, 2001, to reply. A prehearing conference was set for September 5, 2001. No new hearing

dates were established by that Order pending consultation to regarding the Board's availability.

1.6 Subsequent to the prehearing on July 25, 2001, the Presiding Officer was informed that the Board would be available October 31- November 2, 2001. In Prehearing Order No. 10, the Presiding Officer MODIFIED to reflect the new dates for Hearing. The Order also re-scheduled the Prehearing Conference to September 13, 2001.

1.7 A prehearing conference was convened on September 13, 2001. At that time, the Presiding Officer issued a ruling on Respondent's Motion to Exclude, to be memorialized in a separate Order. The Respondent also advised that he would be unavailable for the hearing dates and requested that the dates be rescheduled to November 28-30 (subsequently confirmed by letter dated October 11, 2001). In Prehearing Order No. 11, the Presiding Officer granted the Respondent's request to re-schedule. The Presiding Officer entered a PROTECTIVE ORDER and also reviewed the witnesses and exhibits identified by the parties and determined that there were additional matters to address prior to hearing. Another prehearing conference was scheduled for November 9, 2001, to address any matters relative to the Order of Conduct.

1.8 In Prehearing Order No. 12, the Presiding Officer formalized the provisions of the verbal ruling issued at the September 13, 2001 prehearing conference. The Respondent's motion to exclude the testimony of Dr. Jeffrey Christensen, D.P.M. was DENIED. The Respondent's motion to exclude the testimony

of Dr. Michael Parisot, M.D. was DENIED in part, AND GRANTED, in part. The Presiding Officer ruled that Dr. Parisot would not be permitted to opine whether or where injections should have been given in Patient B's feet. Dr. Parisot was permitted to testify regarding the treatment of infections, to include the use of effective antibiotics and follow-up exams, and whether Amoxicillin was within the standard of care in the treatment of Patient B.

1.9 On October 23, 2001, the Department filed a Motion to Continue the Hearing on the basis that their expert was unavailable. A prehearing conference was held on October 30, 2001, during which alternative dates for hearing were discussed. In Prehearing Order No. 13, a prehearing conference was set for November 21, 2001, to schedule the new hearing dates.

1.10 At the time of the prehearing on November 21, 2001, two sets of dates were obtained from the parties. By letter dated December 6, 2001, the parties were advised of the Board's availability for hearing February 6-8, 2002. In Prehearing Order No. 14, this matter was set for hearing February 6-8, 2002, commencing at 9:00 a.m. at the Holiday Inn SeaTac, 17338 International Blvd., Seattle, Washington 98188.

II. HEARING

2.1 A hearing was held before the Podiatric Medical Board and Health Law Judge Kelly Theriot LeBlanc, Presiding Officer for the Board, on February 6 and 7, 2002, at the Holiday Inn SeaTac, 17338 International Blvd., Seattle, Washington, 98188.

//////////////////////

2.2 The following witnesses testified for the Department:

a. Michael Parisot, M.D. (by telephone)

b. Jeffrey Christensen, D.P.M.

c. Arnold McMullen

2.3 The following witnesses testified for the Respondent:

a. Richard Cowin, D.P.M. (expert witness)

b. Rita Kinney, R.N.

c. Stephen Isham, D.P.M. (the Respondent)

2.4 Exhibits 1 through 15 were stipulated to and admitted at hearing without objection:

Exhibit 1 (Department)	Notebook containing exhibits of Department of Health Tab 1: Records from Sacred Heart Medical Center (Pt. A)
Exhibit 2 (Department)	Notebook containing exhibits of Department of Health Tab 2: Records from Spokane Foot & Ankle Surgery (Pt. A)
Exhibit 3 (Department)	Notebook containing exhibits of Department of Health Tab 3: Records from Spokane Foot & Ankle Surgery (Pt. B)
Exhibit 4 (Department)	Notebook containing exhibits of Department of Health Tab 4: Records from Sacred Heart Medical Center (Pt. B)
Exhibit 5 (Department)	Notebook containing exhibits of Department of Health Tab 5: Second Revised Findings of Fact, Conclusions of Law & Final Order, Docket No. 99-07-A-1035PO
Exhibit 6 (Department)	Representative Drawing Combination Osteotomy prepared by Dr. Jeffrey Christensen
Exhibit 7 (Respondent)	Policy & Procedure Manual for Spokane Foot & Ankle Surgery
Exhibit 8 (Respondent)	Cover sheet identifying Videotape of Tratamiento Quirurgico Percutane del "Hallux Valgus" from Policlinico San Carlos Murcia.
Exhibit 9 (Respondent)	Photographs (8 pages) depicting vascularity following minimal incision osteotomy.

Exhibit 10 (Respondent)	Practice Guidelines from the Academy of Ambulatory Foot Surgery
Exhibit 11 (Respondent)	Compilation of Articles regarding Minimally Invasive Surgery of the Foot and Ankle
Exhibit 12 (Respondent)	Quality Assurance Manual Spokane Foot and Ankle Surgery Center
Exhibit 13 (Respondent)	Informed Consent Videotape from the Spokane Foot and Ankle Surgery Center
Exhibit 14 (Respondent)	Excerpt from the Physician's Desk Reference (55th Edition) pertaining to the use of Sarapin
Exhibit 15 (Respondent)	Manufacturer's Guidelines pertaining to Sarapin Injection Technique in Pain Control published High Chemical Company

2.5 Following the testimony, the Board heard closing arguments from the parties. The Board then met for deliberation in closed session.

III. FINDINGS OF FACT

3.1 The Board has consistently recognized that good results do not always follow from surgeries properly performed and that not all bad surgical results are indicative of improper diagnosis, poor surgical technique, or any other shortcoming of the physician. The Board does not accept the argument that a poor surgical outcome alone constitutes negligence, malpractice, or incompetence in violation of RCW 18.130.180(4).

3.2 The Board has previously rejected the contention that performance of minimally invasive procedures, in and of themselves, violate the standard of care. The Board has recognized and hereby reiterates that some podiatrists have begun using "minimal incision" or "ambulatory" surgical techniques. The Board further recognizes that these procedures can be supported by scientific studies and expertise and are supported by some national organizations.

3.2.1 The Board received evidence demonstrating the techniques associated with minimal invasive procedures, correction of a Hallux Valgus, and performance of the combination osteotomy utilized by Dr. Isham. The Board observed the small burrs and drills that have been fashioned to accomplish the procedures. The Board is satisfied that the procedure can be an appropriate treatment modality in some cases. The Board hereby reiterates its finding that minimal incision surgery is not prohibited by the standards of practice.

3.2.2 However, the Board has also ruled that each podiatric physician and surgeon is responsible for selecting appropriate treatment modalities from the array of procedures and implementing care with appropriate skill and safety. It must be recognized that appropriate application to one patient does not guarantee that application is appropriate for all. Each patient's care must be individually planned and assessed.

3.3 In order to satisfy the standard of care, Dr. Isham must be able to demonstrate that his choice and implementation of treatment is appropriate for each patient that he treats. The Board finds that the mere fact that a procedure has been recognized and accepted as an effective alternative in some cases will not excuse the provider from assessing the procedure as it relates to each patient and for appropriately documenting the assessment of each patient in accordance with standard procedures.

3.4 The Board further finds that Dr. Isham, like all other podiatric physicians and surgeons in the State of Washington, must be able to demonstrate appropriate management of any post operative complications and must adequately document any

and all examinations and interventions taken on behalf of his patients. A failure to do so is inconsistent with the standard of care.

3.5 Stephen A. Isham, D.P.M. testified that he became a podiatrist at the suggestion of his physician father. He graduated from Illinois College of Podiatric Medicine in 1974. His course there did not include a residency program. Dr. Isham began his practice in the state of Washington in 1974. He lives in the state of Idaho and also practices there. Dr. Isham received his Medical Doctorate from the University of Health Sciences, Antigua, in October 2001. He does not anticipate proceeding with Residency training because of competing financial commitments associated with raising his family.

3.6 Dr. Isham began his practice of podiatry using traditional surgical techniques, performing open site surgery. Dr. Isham stated that although initially skeptical, he subsequently became interested in minimal incision surgery. Over the years, his practice has evolved to the point where he practices minimal incision surgery almost exclusively. Dr. Isham has stated a preference of this surgical practice to other forms of treatment. He performs the surgeries in his office center and, because of the pendency of these proceedings, has not attempted to regain privileges in any other facility in the United States. He is the only podiatrist in the state of Washington certified by the Academy of Ambulatory Foot Surgeons. He is also certified and receives reimbursement from Medicare.

//////////////////////

//////////////////////

3.7 Dr. Isham serves as an adjunct associate professor of foot surgery for the school of medicine of the Universidad de Alcala de Henares in Madrid, Spain. He is fluent in the Spanish language and teaches via videotape as well as in person. He occasionally videotapes surgeries for use in this instruction. He has also accepted foot surgeons in his office during the residence portion of their training.

3.8 Dr. Isham maintains a busy practice. His office consists of a surgical nter side and an examination/treatment side. His staff consists of two nurses and various clerical staff. On the examination/treatment side, the nurses do patient intakes and interviews, perform palliative care, and take x-rays. On the surgical center side, the nurses prepare the patients for surgery.

3.9 Dr. Isham is active in his community. He provides free podiatric care to those who cannot afford services or receive care elsewhere.

3.10 Dr. Isham states he has used a variety of methods for maintaining patient records. Early during his own practice, he developed a medical history form and a progress note form. His nurse would complete the medical history form when the patient arrived for the first appointment and would make any necessary additions on later visits. Dr. Isham also made notes on the medical history form. He contends his ormal practice was to make all observations called for by the forms. If he makes no entry in a particular area, Dr. Isham testified that this indicates that he considered the findings to have been within the normal range.

3.11 Dr. Isham writes diagnoses and procedures using a "SCAP" format. In some instances, he also adds comments under "I" which he relates are for his

impressions of what might be going on with a patient. Dr. Isham related that he tried to document contemporaneously with the patient contact.

3.12 Dr. Isham and Rita Kinney described the preoperative procedures to the Board. Both indicated that the patients vitals are recorded and a review of the patient's history is conducted by both nurse and later, by Dr. Isham. The nurse briefly explains the operating room routine and takes the patient into the conference room to view the surgical video. (Exhibit 13). After the video is over, Dr. Isham then explains the proposed surgical procedures to his patients. The patient is permitted and encouraged to ask questions. Generally, the surgery is scheduled for a later date. On the day of surgery, one of the nurses prepares the patient for surgery in the surgical room and provides an informed consent form for the patient to sign. The patient can ask more questions at that time if the patient desires to do so. The surgical consent form has been modified at various times. The nurse witnesses the consent form.

3.13 Rita Kinney, R.N., testified at length regarding the development of policy and procedure, office practices, quality improvement practices, and Medicare inspection protocols and requirements. Ms. Kinney also offered testimony concerning her contacts with the patients involved in these proceedings. Ms. Kinney indicated that she did the intake on Patient A and obtained the patient's history. Ms. Kinney was not involved with the surgery or the follow up visits with this patient. Ms. Kinney was involved with Patient B's initial contact with Dr. Isham in 1995, and the visit on March 17, 1997, when the Sarapin injection was administered. Ms. Kinney was not involved in the visit of

//////////////////////

March 10, 1997. Ms. Kinney indicated that she suspected that Patient B's infection was attributed to his living conditions and was unrelated to the procedure itself.

Patient A

3.14 Patient A's testimony was offered by telephone. He indicated that he will be 84 years old in July. According to Patient A, his medical history includes a tonsillectomy, hemorroidectomy, heart surgery and stent implant. Patient A related that he'd also had a hammertoe procedure done once before with Dr. Romney and hadn't had any problems recovering then.

3.15 He said he went to see Dr. Isham in 1996 because he was having trouble with his foot. Patient A's brother had received care from Dr. Isham and recommended him. Patient A did not know what he had been diagnosed with and was unable to describe his understanding of the surgery. He said that he thinks Dr. Isham ground some of the bones out of his toes with an instrument like the dentist uses.

3.16 Patient A indicated that after the surgery, his toes were very sore and discolored. He believes that the pain was immediate. Patient A opined that "after the circulation was damaged, those toes started to die." He said that the pain and discomfort got worse so he went to see Dr. Isham.

3.17 Patient A testified that he believed that his toes were black by the second or third day. He related that the Epsom salts and medication he received from Dr. Isham were not working so when he went back to see Dr. Isham two or three days later, Dr. Isham called Dr. Oakley, an infectious disease specialist. Dr. Oakley admitted him

//////////////////////

right away and told his wife he might lose his foot. He recalls receiving massive antibiotics and reported that he only lost two toes instead of part of his foot.

3.18 According to Dr. Isham's records (Exhibit 2), Patient A was initially examined on March 26, 1996, and elected to have the minimally invasive surgery. The note reflects pulses of 2/5 and capillary refill of less than 2 seconds. There were no other vascular studies performed prior to the procedure. The surgery took place on March 29, 1996.

3.19 Patient A was seen postoperatively on April 1, 1996, complaining of pain. Dr. Isham's notes reflect that he found no drainage or area of concern. However, Dr. Isham was concerned that the pain was atypical and prescribed Amoxicillan. The records further reflect that the prescription was then changed to Erythromycin following telephone notification from Patient A's wife that regarding an previously undisclosed drug allergy. (Exhibit 2).

3.20 On April 3, 1996, Dr. Isham noted that Patient A's toes were definitely black (attributed to infection in the notes of his "impressions"), a culture and sensitivity was performed, and Dr. Isham referred him to an infectious disease specialist. (Exhibit 2).

3.19 Patient A was admitted to Sacred Heart Medical Center on April 3, 1996, with an initial diagnosis of wet gangrene of the 2nd and 3rd toes of his left foot. (Exhibit 3) He underwent amputation of the 2nd and 3rd toes with debridement of the foot wound that date. Following surgery, the intial diagnosis was confirmed.

//////////////////////

Patient B

3.20 Patient B did not testify.

3.21 The medical records pertaining to his care and treatment at the Spokane Foot & Ankle Surgery Center (Exhibit 3) and Sacred Heart Medical Center (Exhibit 4) were admitted without objection. Patient B had a medical history significant for hepatic failure, secondary to alcohol abuse and dependency. He was apparently residing in a half-way house at the time of his treatment with Dr. Isham, although that fact was not initially known.

3.22 Dr. Isham testified that his initial contact with Patient B was in June 1995, during which he noted positive molar sign and observed him to have plantar flexed 3rd and 4th metatarsals with a neuroma.

3.23 He next saw Patient B on March 10, 1997. Dr. Isham recommended an anti-inflammatory and noted his plan to continue with orthotics if problems persisted. Dr. Isham indicates that he administered the Sarapin on that date.

3.24 Although not reflected in the record, Dr. Isham testified that he used 1 cc. of Sarapin for each digit. Dr. Isham also indicated that it would have been his practice to administer two separate injections in the interspace, although his chart notes do not reflect placement or number of injections.

3.25 Dr. Isham indicated that the Sarapin is delivered from multi-use vials but he was unable to state whether the vial he used for Patient B had already been opened or used on any other occasion.

//////////////////////

3.26 Patient B returned on March 13, 1997, for casting for orthotics. The notes reflected that the foot appeared normal but there was definitely pain illicited in the interspace of the 2nd and 3rd digit. Relafen was prescribed to relieve pain.

3.27 Patient B called Dr. Isham at his home on March 16, 1997, advising that his foot was swollen and quite painful. Dr. Isham testified that he was unable to leave to go see the patient because his son was ill. Although not reflected in his notes, Dr. Isham testified that he advised the patient to go to the emergency room and Patient B refused. Dr. Isham said that he then elected to prescribe Amoxicillan to provide broad spectrum prophylaxis and advised Patient B that he would see him first thing the next morning.

3.28 Dr. Isham saw Patient B on the morning of March 17, 1997, and noted that he presented with "a red swollen left foot, bright red." His notes reflect that Patient B described some improvement since he began taking the medication. Dr. Isham noted no drainage and no focal area of infection. He advised Patient B to go home and rest, not to ambulate on his foot but to do active exercises to move and stimulate the circulation. Dr. Isham advised Patient B that if his symptoms did not improve, he was going to refer him to an infection specialist.

3.29 On March 18, 1997, Patient B called Dr. Isham and stated that he felt that his condition was deteriorating. Dr. Isham advised him to immediately contact his primary physician for admission and treatment with IV antibiotics. Although not noted in the records, Dr. Isham indicates that Patient B stated that he did not want to go to the hospital but would rather go to see his brother, who was a physician. Dr. Isham

testified that he told Patient B not to delay in contacting his brother and if he could not reach him, to proceed to the hospital. Dr. Isham did not have any additional contact with the patient following the telephone conversation.

3.30 According to his records, Patient B was thereafter seen at the South Hill Medical Center by a physician's assistant on March 18, 1997; by Dr. Mark Johnson on March 19, 1997; and finally by Dr. Michael Parisot on March 20, 1997. On March 18, Patient B received some antibiotic therapy but the infection was not marked. On March 19, Dr. Johnson did mark the infection and on March 20, upon noting the acceleration, Dr. Parisot admitted Patient B to Sacred Heart Medical Center with an intial diagnosis of abcess of the left foot. During the course of his admission, he underwent debridement of the left foot and utimately, a right latissimus dorsi muscle transplantation with split thickness skin grafts to repair the area. (Exhibit 4). Patient B spent 26 days at Sacred Heart followed by another 36 days in extended care for rehabilitation.

Alleged Violations

3.31 The care provided by Dr. Isham to these two patients is at issue in this proceeding.

3.32 The Department contends that Dr. Isham's performance of a double osteotomy on the second and third digits of Patient A's left foot and the post operative management of the patient was below the standard of care resulting in infection, gangrene and ultimately the amputation of Patient A's toes.

//////////////////////

3.33 The Department contends that the use of the drug Sarapin in the foot of Patient B the injection and asepsis technique; the failure to document the amount injected; inappropriate management of infection; and subsequent use of the multi-dose vial on other patients violated the standard of care.

3.34 Dr. Jeffery Christensen, D.P.M. and Dr. Michael Parisot, M.D., reviewed these matters as expert witnesses for the Department. While both experts were provided with care records for the patients, neither of them had conversations with Dr. Isham or subsequent providers involved with these patients.

3.35 Dr. Christensen, testifying for the Department, found Dr. Isham's care to be substandard in various respects regarding both patients.

3.35.1 With respect to Patient A, Dr. Christensen testified that in his opinion, performance of a "combination osteotomy" utilizing the minimally invasive technique violates the standard of care.

a. Dr. Christensen opined that the procedure itself posed an unreasonable risk because the incision precludes visualization and retraction of the vascular structures.

b. Dr. Christensen also felt that the minimally invasive technique creates increased risk of thermal necrosis.

c. Dr. Christensen further opined that the use of the procedure on Patient A, in particular, was contraindicated by his history of cardiovacular problems, aspirin therapy, and evidence of poor vascularity reflected in the patient history documented by Dr. Isham.

d. Dr. Christensen further opined that Dr. Isham failed to appropriately assess the vascularity of the patient preoperatively.

e. Dr. Christensen felt that the complications manifested by Patient A reflected vascular compromise that was not appropriately recognized or treated by Dr. Isham.

3.35.2 With respect to Patient B, Dr. Christensen testified that the use of Sarapin in the foot violates the standard of care.

a Dr. Christensen opined that Sarapin is an obscure medication and that there is no indication for its use in the foot.

b Dr. Christensen further testified that he found a discrepancy between Dr. Isham's statements and those of the patient regarding injection and asepsis technique.

c Dr. Christensen was critical of Dr. Isham's failure to document the volume and location for the injections indicating, in his opinion, that alone was sufficient to establish a violation of the standard of care.

d Dr. Christensen felt that the multi-use vial and combination of open procedure with the hallux valgus could also have contributed to the development of infection in this patient.

e Finally, Dr. Christensen opined that the post procedure management and lack of provider directed referrals for Patient B fell below the standard of care.

//////////////////////

3.36 Dr. Richard Corwin, D.P.M., testified on behalf of Dr. Isham. Dr. Corwin indicated that he utilizes both open procedures and minimally invasive techniques in his practice but by preference, would always use minimally invasive techniques because of what he perceived to be less risk and better results for the patients. Dr. Corwin also indicated that he commonly utilized Sarapin in the course of his practice. Dr. Corwin testified that he reviewed the course of treatment involving both patients. Dr. Corwin opined that Dr. Isham's treatment of Patient A and Patient B were within standard of care.

3.36.1 Dr. Corwin was critical of Dr. Christensen's qualifications to render an opinion on minimally invasive techniques or the use of Sarapin, given his admitted lack of expertise regarding the procedures and absence of knowledge regarding the pharmacological uses of the medication.

3.36.2 Dr. Corwin opined that Dr. Christensen also lacked a basic understanding of the technique and the instrumentation used in minimally invasive surgery. Dr. Corwin indicated that there is a vast difference in the size and amplitude compared to some of the burrs and bits used in open procedures.

3.36.3 With respect to Patient A, Dr. Corwin opined that he felt that use of a broad spectrum antibiotic followed by the decision to refer Patient A for an infectious disease consult was appropriate.

3.36.4 Similarly, he felt that allowing Patient B to select his preference from the defined options offered by Dr. Isham was in accordance with standards.

//////////////////////

3.36.5 Dr. Corwin did not agree that provider directed referral is required. He indicated that he perceived that the receiving provider had a duty to obtain information if needed to formulate a plan for definitive diagnosis.

3.37 The Board has previously recognized that minimal incision surgery is a recognized method of surgery, supported by national organizations, based on scientific studies and expertise, and not prohibited by the standards of practice in Washington. Since the Board has already opined on the propriety of the use of minimal incision surgery, it is not at issue in this case. The Board first notes that Respondent has not challenged Dr. Christensen's qualifications to offer expert testimony in this case. However, to the extent that Dr. Christensen offered opinions inconsistent with previous opinions of the Board, they are rejected.

3.38 Dr. Michael Parisot, M.D., testified that he is Patient B's step-brother. He acknowledged a long standing association as Patient B's treating physician. With respect to the allegations before the Board, Dr. Parisot's first contact with Patient B was as a subsequent provider. Patient B had seen two other providers within Dr. Parisot's group prior to his consult on March 20, 1997. Dr. Parisot was informed that Patient B had received Amoxicillan from Dr. Isham four days earlier on March 16, 1997.

3.38.1 Dr. Parisot opined that the use of Amoxicillan to treat an infection encountered in the Podiatry practice is contraindicated and violative of the standard of care.

//////////////////////

//////////////////////

3.38.2 Dr. Parisot opined that Dr. Isham's failure to appropriately manage the infection, to include an inadequate referral pattern, caused the complications experienced by Patient B.

3.39 During cross examination, Dr. Parisot acknowledged that neither he nor any of the other subsequent providers had requested information or attempted contact with Dr. Isham in the course of caring for Patient B. Dr. Parisot further indicated that he did not believe that contact with Dr. Isham was necessary for any of the providers to appropriately assess Patient B. Dr. Parisot indicated that he was not critical of any of the care offered by the subsequent providers.

3.40 Respondent's Counsel asked Dr. Parisot if he had any knowledge of what referral options had been discussed with Patient B. Counsel then outlined the referral options that Dr. Isham said were offered to Patient B and asked if Dr. Parisot would be critical of those options. Dr. Parisot agreed that if those options had been discussed with Patient B, he would concur that Dr. Isham's referral pattern would have been appropriate.

3.41 The Board has previously ruled that each podiatric physician and surgeon is responsible for selecting appropriate treatment modalities from the array of procedures and implementing care with appropriate skill and safety.

3.42 The Board finds that the care provided by Dr. Isham to each individual patient must be measured against the applicable standard of care. It must be recognized that appropriate application to one patient does not guarantee that application is appropriate for all. Each patient's care must be individually planned and

assessed. Accordingly, the Board finds that the mere fact that a procedure has been recognized and accepted as an effective alternative in some cases cannot excuse the provider from assessing the procedure as it relates to each patient and for appropriately documenting the assessment of each patient in accordance with standard procedures.

IV. CONCLUSIONS OF LAW

4.1 Dr. Isham is licensed to practice as a podiatric physician and surgeon in the state of Washington. He is subject to the provisions of chapters 18.22 RCW and 18.130 RCW and chapter 246-922 WAC.

4.2 Pursuant to WAC 246-11-520, the burden is on the Program to prove the factual allegations set forth in the Statement of Charges by a preponderance of the evidence. The Board recognizes that the Washington Supreme Court has held recently that the standard of proof in disciplinary proceedings against physicians before the Washington State Medical Quality Assurance Commission is now proof by clear and convincing evidence. Nguyen v. Department of Health, Medical Quality Assurance Commission, 144 Wn.2d 516, 29 P.3d 689 (2001)(hereafter Nguyen). However, the Washington Court of Appeals has since held that Nguyen should not necessarily be extended to disciplinary proceedings against all professional licensees. Eidson v. Department of Licensing, 108 Wn.App. 712, 32 P.3d 109 (2001). Given the legal uncertainty regarding the standard of proof in disciplinary proceedings against the podiatric profession, the Board concludes that the standard of proof in this proceeding shall remain preponderance of the evidence, pending further legislative or judicial guidance. However, recognizing that the standard of proof applicable to this

proceeding may subsequently be determined to be clear and convincing evidence, the Board has elected to consider the evidence under both the clear and convincing standard and the preponderance of the evidence standard.

4.3 The Board may exercise its own professional expertise in reviewing the analysis and opinions of expert witnesses offered by the parties. RCW 34.05.461(5). The Board chooses to do so in this case.

Patient A

4.4 While the Board reaches no conclusion as to whether Dr. Isham's choice to proceed with minimal invasive surgery was appropriate, the Board does find that given Patient A's medical history and noted vascular response as reflected in Dr. Isham's records, a more comprehensive vascular assessment was warranted before any procedure or treatment modality was selected. In this regard, the Board concludes that Dr. Isham's failure to conduct and document an appropriate pre-operative assessment of Patient A fell below the standard of care in violation of RCW 18.130.180(4), (7) and WAC 246-922-260.

4.5 The Board further concludes that Dr. Isham's management of the post operative complication was below the standard of care in that he failed to recognize and treat the potential vascularize compromise Patient A was experiencing. In so holding, the Board draws relies from the testimony of Patient A and Dr. Isham regarding the onset and character of symptoms. The Board takes particular note of the immediacy and description of the pain described by Patient A and ratified through the testimony and records of Dr. Isham. The Board also relies upon the observations and testimony

of Dr. Christensen in concluding that Dr. Isham should have immediately recognized the potential for a vascular etiology. The Board concludes that Dr. Isham's failure to respond and intervene in a timely fashion violated RCW 18.130.180(4) and resulted in Patient A developing infection, gangrene, and ultimately, the loss of two of his toes.

Patient B

4.6 The Board concludes that the Department has failed to establish that the use of Sarapin in pociatric applications violates the standard of care. Dr. Corwin indicates that the use of Sarapin is routinely utilized in his practice. While it remains unclear to what extent Dr. Corwin's experience is reflective of others within the Podiatric field, Dr. Corwin testified that he learned of the medication through his affiliation with the American Academy of Pain Management seven or eight years ago. Dr. Corwin also testified that there are other Podiatric practitioners affiliated with the Academy and that, in his opinion, Sarapin is widely used at this time. Other than the testimony of Dr. Christensen, who readily acknowledged that he had no familiarity with the drug, the Department offered no additional testimony on the use of Sarapin in Podiatric applications. The Board notes reference to its use in conjunction with carpal tunnel, tendonitis, sciatica, and trigeminal neuralgia. The Board further notes that while the manufacturer's information does not contain any reference to podiatric uses, the Physician's Desk Reference does indicate that it is appropriate for use in local infiltration (Exhibit 14, 15). Consequently, the Board is not prepared to accept the Department's contention that the use of Sarapin has no valid application in Podiatric medicine.

4.7 While the use of Sarapin may be an appropriate intervention in some cases, this does not excuse the provider from assessing the procedure as it relates to each patient and for appropriately documenting the assessment of each patient in accordance with standard procedures. In this instance, it is clear, both from Dr. Isham's testimony and Patient B's medical records, that Dr. Isham failed to appropriately document the volume of Sarapin used; failed to document the number of injections; and the placement of the injections administered to Patient B (Exhibit 3). The Board further accepts the testimony of Dr. Christensen on the issue of documentation in concluding that Dr. Isham's conduct fell below the standard of care and violated RCW 18.130.180 (4), (7), and WAC246-922-260.

4.8 The Board rejects the contention that the mere use of a multi-use vial violates the standard of care and moreover, concludes that the Department has produced no evidence which would indicate that Dr. Isham had cause to believe that use or reuse of the vial in this case posed an unreasonable risk to Patient B or any other patient.

4.9 While the Board concurs that WAC 246-922-090 does provide that the Podiatrist is ultimately responsible for all treatments performed at his direction, the Board also rejects the contention that delegation to another appropriately credentialed provider is inconsistant with that obligation. The uncontroverted testimony of Dr. Isham suggests that referral options were given to Patient B and a preference was expressed by the Patient. The Respondent's expert, Dr. Corwin, testified that the referral pattern described by Dr. Isham met the standard of care. Furthermore, when presented with

those referral options during cross examination, Dr. Parisot , the Department's expert, opined that the referral pattern was appropriate. Accordingly, the Board has no evidence before it to support a finding that Dr. Isham's tendered referrals for Patient B were inappropriate.

4.10 The Board is concerned by Dr. Isham's admission regarding his inexperience in the realm of managing infections. Infections are a widely recognized complication that can impact any patient. The ability to appropriately recognize and treat infections is well within the obligations of the podiatric practitioner. Dr. Isham testified that it is his practice to refer all patients who do not respond to oral antibiotics to a specialist for management. While the Board has not concluded that his delegation of care in these cases is sufficient to constitute *per se* violations of the standard of care, the Board does find that Dr. Isham's practice in this regard could present an undue risk for his patients. The Board finds that additional training in the area of wound care and infection control would be of benefit to Dr. Isham.

4.11 While the Board is not prepared to accept the contention that prescribing Amoxicillan in a Podiatric setting constitutes a violation of the standard of care, the Board does conclude that the act of prescribing any medication in the absence of a definitive examination and diagnosis violates the standard of care. In this case Dr. Isham received information from Patient B via telephone under circumstances where he was not clear of the origin and etiology of the problem. By his own testimony, Dr. Isham acknowledged that he could not appropriately assess the patient and was not sure what was going on. Accordingly, his decision to proceed with pharmacological intervention

did not meet the standard of care and violates the provisions of RCW 18.130.180(4) .

4.12 Based on the above violations of law, the Board concludes that imposition of an appropriate sanction, pursuant to RCW 18.130.160, is warranted. The Board concludes that the violations are serious in nature, in that the violations caused bodily harm to the patients, and thus, the violations require serious sanctions. The sanctions are set forth below.

V. ORDER

Based on the foregoing Procedural History, Findings of Fact, and Conclusions of Law, the Board hereby makes the following ORDERS:

5.1 Stephen A. Isham, D.P.M. shall be required to complete additional training in the areas of vascular assessment, wound care, and infection control through the University of Texas, Health Sciences, courses offered by Lawrence Harkless. The courses must be completed within 9 months following entry of this Order.

5.2 Within 90 days following his completion of these courses, Dr. Isham shall prepare an article for publication in a journal regarding appropriate recognition and management of post operative complications and infections resulting from minimally invasive surgery techniques. The draft is to be provided to the Board for consideration and approval prior to submission for publication.

5.3 Dr. Isham shall pay an administrative fine of $15,000, representing a fine of $5,000 for the stated violations regarding Patient A (para. 4.4 - 4.5) and $10,000 for the separately stated violations concerning Patient B (para 4.11 and 4.15), within 90 days of service of this Order. The check shall be made payable to the State Treasurer,

mailed to the Department of Health, Podiatric Medical Board, PO Box 1099, Olympia WA 98507-1099.

5.4 Nothing herein shall be deemed to impact the obligations or provisions of the terms of the Second Revised Final Order, in Cause No. 99-07-A-1035PO.

5.5 If the Respondent violates any provision of this order in any respect, the Board, after giving the Respondent notice and the opportunity to be heard, may impose any sanction as appropriate under RCW 18.130.160 to protect the public, or may take emergency action ordering summary suspension or restriction or limitation of the licensee's practice as authorized by RCW 18.130.050.

5.6 This Order is subject to the reporting requirements of RCW 18.130.110, Section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements.

5.7 Within 10 days of the effective date of this Order, the Respondent shall thoroughly complete the attached Healthcare Integrity and Protection Data Bank Reporting Form (Section 1128 of the Social Security Act) and return it to the Adjudicative Clerk Office, 1107 Eastside Street, PO Box 47879, Olympia, Washington, 98504-7879.

5.8 The Respondent shall obey all federal, state and local laws and all rules governing the practice of the podiatric profession in Washington.

5.9 The Respondent is hereby placed on notice that it is the responsibility of the Respondent to ensure that all required reports are submitted to the Disciplining Authority in a timely manner.

5.10 Upon successful completion of this order, the Respondent may petition of the board for reinstatement of license or removal of conditions.

5.11 The Respondent shall submit written notification to the Board, addressed to the Program Manager, of any employment or residence address changes. The notification shall include the complete new address and telephone number. The notification must be made within 20 days of the change in employment or residence address.

VI. NOTICE TO PARTIES

THE PARTIES ARE FURTHER ADVISED, pursuant to RCW 34.05.461 and 34.05.470, that within 10 days of service of this Final Order, you may file a petition for reconsideration with the Adjudicative Clerk Office, 1107 Eastside Street, PO Box 47879, Olympia, WA 98504-7868. The petition shall state the specific grounds upon which relief is requested. The petition for reconsideration shall not stay the effectiveness of this Final Order. The petition is deemed to have been denied if, within 20 days of the date of its filing, the Adjudicative Clerk Office has not disposed of your petition or has not served you with written notice specifying the date by which action will be taken on your petition.

"Filing" means actual receipt of the document by the Board. RCW 34.05.010(6). This Final Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

//////////////////////

Proceedings for judicial review may be instituted by filing a petition in the Superior Court in accord with the procedures specified in Chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. The petition for judicial review must be filed within 30 days after you have been served with this Final Order, as provided by RCW 34.05.542.

DATED THIS 14 DAY OF MARCH, 2002.

PODIATRIC MEDICAL BOARD

William Ith, Public Member
Panel Chair

FOR INTERNAL USE ONLY: (Internal tracking numbers)
Program No. 97-05-0002 & 96-05-0002

COPY

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PODIATRIC MEDICAL BOARD

In the Matter of the License to Practice as a Podiatric Physician and Surgeon of: STEPHEN A. ISHAM, D.P.M., License No. PO0185, Respondent.	Docket No. 99-07-A-1035PO SECOND REVISED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER

INTRODUCTION

On June 8, 1995, the Podiatric Medical Board (the Board) issued Findings of Fact, Conclusions of Law, and a Final Order (the Final Order) regarding the license to practice podiatric medicine and surgery held by Stephen A. Isham, D.P.M. (the Respondent). The Department of Health (the Department) moved for reconsideration of the Order, contending that the Order addressed issues that had not been contained in the Statement of Charges. The Respondent did not respond to the motion for reconsideration. The Board granted the Department's motion and on, September 12, 1995, issued a Revised Findings of Fact, Conclusions of Law and Final Order (Revised Order). The Respondent appealed the Revised Final Order. On June 25, 1999, Superior Court Judge Michael E. Donohue signed Findings of Fact, Conclusions of Law and Order Remanding and Reversing (Order Remanding and Reversing). After considering the oral argument made by the parties on November 12, 1999, the Order Remanding and Reversing, the transcript of the proceedings and the admitted exhibits, the Board hereby issues the following:

I. SECOND REVISED PROCEDURAL HISTORY

1.1 A Statement of Charges was issued on February 10, 1994, alleging that the Respondent, Stephen A. Isham, D.P.M., had committed acts of unprofessional conduct in violation of specified subsections of RCW 18.130.180. A Notice of Opportunity to Defend and Notice of Hearing was also issued on February 10, 1994.

1.2 The Respondent filed his Application for Adjudication, dated February 14, 1994, and received by the Podiatric Medical Board on February 22, 1994. Dr. Isham denied the allegations and requested a hearing. He indicated that he would be represented by his attorneys, D. E. McKelvey and Timothy B. Fennessy.

1.3 A Scheduling Order was issued on February 23, 1994, setting dates for completion of settlement negotiations and discovery, a cut-off date for motions, a prehearing conference, and the hearing. By subsequent agreement of the parties, the prehearing conference was continued to July 12, 1994. The parties were notified of the changed date by letter dated June 14, 1994, from the Office of Professional Standards, the office of the Presiding Officer.

1.4 Both parties submitted prehearing statements on July 6, 1994. John Keith, Assistant Attorney General, subsequently provided a substitute copy of Department's proposed exhibit A-1 to substitute for documents erroneously included in the Department's prehearing statement. A Final Prehearing Order was issued on August 16, 1994.

Exhibit B
Page 1 of 27

1.5 The Respondent filed his Motion to Add Witnesses and Exhibits, dated and faxed August 5, 1994, and his Supplemental Motion to Add Witnesses and Exhibits, dated and faxed August 11, 1994. The Department filed its Reply to Respondent's Motion and Supplemental Motion to Add Witnesses and Exhibits, dated and faxed August 17, 1994. The Respondent's motion and supplemental motion were g. ed in part and denied in part by oral ruling of the Presiding Officer.

1.6 A hearing was held before the Washington State Podiatric Medical Board and Health Law Judge Margaret J. Gilbert, Presiding Officer for the Board, on August 22, 23, 24, 25, and 26, 1994, and December 12, 13, 14, 15, and 16, 1994, at the Inn at the Park, Spokane, Washington. Board members hearing and deciding the case were Ireda Grohs, Cynthia Fenberg, D.P.M., and Charles Waller, D.P.M. Assistant Attorney General John H. Keith represented the Department. Dr. Isham was present throughout the hearing and was represented by his attorney, Daniel E. McKelvey.

1.7 The following witnesses testified for the Department:

a. Leona Mary "Sunny" Gadd (also testified as a rebuttal witness);
b. Jean Winship (also testified as a rebuttal witness);
c. Pamela N. Mueller;
d. Kimberly K. Wiltshire (Coleman);
e. Vera Gushalak;
f. Sigvard T. Hansen, Jr., M.D. (via videotaped deposition shown at hearing by agreement of the parties);
g. Thomas Osten, M.D. (via videotaped deposition shown at hearing by agreement of the parties);

h. Stephen J. Miller, D.P.M.; and
i. David T. Morton, D.P.M.

1.8 The following witnesses testified for the Respondent:

a. Stephen D. Weissman, D.P.M.;
b. Rita Kinney, R.N.;
c. Don Taylor;
d. Corinne Castle;
e. Glenna Nirenberg, R.N.;
f. Yvonne Hoffman;
g. Stephen Isham, D.P.M. (the Respondent); and
h. Patricia Haye.

1.9 Exhibits 1 through 22 were admitted at hearing:

Exhibit 1	Notebook containing exhibits of Department of Health.
Exhibit 2	X-rays of Mrs. Gadd (8 films).
Exhibit 3	X-rays of Mrs. Winship (12 films).
Exhibit 4	X-rays of Mrs. Mueller (4 films).
Exhibit 5	X-rays of Mrs. Wiltshire (7 films).
Exhibit 6	X-rays of Mrs. Gushalak (5 films).
Exhibit 7	Videotape of surgery on Mrs. Gushalak.
Exhibit 8	Videotape of deposition of Dr. Hansen.
Exhibit 8.1	Curriculum Vitae of Sigvard T. Hansen, Jr., M.D.
Exhibit 8.2	Patient records of Leona Mary Gadd.

Exhibit B
Page 2 of 27

Exhibit 8.3	Patient records of Jean Winship.
Exhibit 9	Videotape of deposition of Dr. Osten.
Exhibit 10	Transcript of deposition of Dr. Osten (sealed original).
Exhibit 11	Notebook containing exhibits of the Respondent.
Exhibit 12	Drawing by Mrs. Wiltshire.
Exhibit 13	Transcript of deposition of Vera Gushalak.
Exhibit 14	Curriculum Vitae of Stephen J. Miller, D.P.M.
Exhibit 15	Curriculum Vitae of Stephen D. Weissman, D.P.M.
Exhibit 16	Drawing of Z-tendonotomy by Dr. Weissman.
Exhibit 17	Drawing of dorsal osteotomy by Dr. Weissman.
Exhibit 18	ABAFS Standards for Surgery.
Exhibit 19	Med Video Productions videotapes of four foot surgery procedures.
Exhibit 20	Curriculum Vitae of Stephen A. Isham, D.P.M.
Exhibit 21	Patient chart of unidentified 46-year-old patient.
Exhibit 22	Patient chart of unidentified 25-year-old patient.

1.10 The Board issued Findings of Fact, Conclusions of Law, and Final Order, which was signed on June 2, 1995, and was served on the Respondent on June 8, 1995.

1.11 The Department moved for reconsideration on June 15, 1995. The Respondent did not respond to the motion for reconsideration.

1.12 Health Law Judge Eric B. Schmidt was substituted for Judge Gilbert as Presiding Officer on June 15, 1995.

1.13 On June 21, 1995, the Presiding Officer issued an Order on Petition for Reconsideration, which found the Department's motion was timely and which stayed the enforcement of the administrative fine penalty until the motion for reconsideration was addressed.

1.14 On September 12, 1995, the Board issued a Revised Findings of Fact, Conclusions of Law and Final Order (the Revised Final Order). The Respondent appealed the Revised Final Order to the Superior Court for Spokane County.

1.15 This appeal came before Superior Court Judge Michael E. Donohue, who on June 25, 1999, signed Findings of Fact, Conclusions of Law and Order Remanding and Reversing (Order Remanding and Reversing). He found that there was no substantial evidence to support the Board's conclusion that the Respondent had violated RCW 18.130.180(1), but found that there was substantial evidence to support the Board's conclusions that the Respondent had violated RCW 18.130.180(4), (7), and (13).

1.16 On August 4, 1999, Senior Health Law Judge Eric B. Schmidt issued an Order Following Order Reversing and Remanding. He ordered that the Board shall engage in further consideration of the facts, conclusions and sanctions in this matter and that the Board shall issue a further revision of the Revised Final Order. He also ordered that the parties shall be allowed to present oral argument, but shall not be

permitted to present new evidence.

1.17 On October 20, 1999, the Adjudicative Clerk Office issued an Amended Notice of Further Consideration notifying the parties that this matter will be reviewed by Board on November 12, 1999.

1.18 During the proceeding on November 12, 1999, the Board heard oral a ent from the parties. Then the Board met in closed session to consider the Order Remanding and Reversing, the transcript of the proceedings and the admitted exhibits.

II. SECOND REVISED FINDINGS OF FACT

General Aspects of Podiatric Practice

2.1 Traditionally, podiatric surgery on the bones of the forefoot has been performed as open site surgery. Successive layers of tissue are separated to reach the bone(s) below. Following surgery, some internal or external immobilization device is generally utilized along with dressing to support the foot during healing. Patients are generally instructed not to walk on the foot for a period of time. In recent years, some podiatrists have begun using "minimal incision" or "ambulatory" surgical techniques. small cuts are made in the tissues and the bones below are operated upon using small burrs and drills. "Fixation" is accomplished by application of external soft dressings and the patients are encouraged to "walk to tolerance" almost immediately after surgery and throughout the healing process. Minimal incision surgeons believe that a degree of mobility of the affected tissues, including any bones, is desirable and promotes healing.

2.2 The majority of podiatric surgeons in the state of Washington still practice primarily traditional forefoot surgery. Only a minority practice any amount of minimal incision surgery.

2.3 A common deformity of the forefoot is the "bunion" or hallux abducto valgus. Various bunionectomy procedures have been developed to correct the underlying deformities and relieve the symptoms of bunions.

2.4 In about 1985, Dr. Isham developed the Reverdin-Isham bunionectomy procedure. The procedure is performed using minimal incision surgery and involves taking a wedge of bone from the head of the first metatarsal bone head (a wedge osteotomy). When the wedge site is closed and the bone healed, the bone is realigned and the bunion reduced. (See Tab C-F of Exhibit 11). Dr. Isham states he has had good success with the procedure and has demonstrated the procedure in Spain and China.

2.5 Wedge osteotomies are also used by practitioners of minimal incision surgery to raise or lower the position of the heads of metatarsal bones.

2.6 A period of time is required for healing of a wedge osteotomy. The testimony in this case suggests a normal period of time for initial healing is about six to eight weeks. Full healing may take six months or more. When healing is not as rapid as normally expected but is progressing at some pace, "delayed healing" is said to have occurred. When full healing has not occurred after a considerable period of time and no additional healing is occurring, "non-union" is said to have occurred.

2.7 Taylor's bunion is a deformity involving the fifth metatarsal and the fifth toe, which is in many respects similar to a bunion except that it occurs on the outside of the foot. Taylor's bunion is also called bunionette.

2.8 A neuroma is a tumor consisting of a nerve surrounded by fibrous tissue. These occur between the metatarsals and can cause pain. They are generally benign (noncancerous) growths.

General Aspects of Dr. Isham's Practice

2.9 Stephen A. Isham, D.P.M. became a podiatrist at the suggestion of his physician father. He graduated from Illinois College of Podiatric Medicine in 1974. His course there did not include a residency program. Dr. Isham began his practice in the state of Washington in 1974. He lives in the state of Idaho and also practices there.

2.10 Dr. Isham began his practice of podiatry using traditional surgical techniques, performing open site surgery. As a podiatrist, he encountered difficulty gaining hospital privileges in the Spokane area and having Medicare approve his surgeries for payment. Dr. Isham states he became interested in minimal incision surgery as a result of these difficulties. He also related his own dissatisfaction with his success utilizing traditional surgical techniques. He also opened his own surgical center within his office complex. Today he practices minimal incision surgery almost exclusively, prefers surgical practice to other forms of treatment, and performs the surgeries in his office center. He is the only podiatrist in the state of Washington certified by the Academy of Ambulatory Foot Surgeons.

2.11 Dr. Isham serves as an adjunct associate professor of foot surgery for the school of medicine of the Universidad de Alcala de Henares in Madrid, Spain. He is fluent in the Spanish language and teaches via videotape as well as in person. He occasionally videotapes surgeries for use in this instruction. He also accepts foot surgeons in his office during the residence portion of their training.

2.12 Dr. Isham maintains a busy practice. His office consists of a surgical center side and an examination/treatment side. The office is not open every day of the week, but when it is open, he performs two to five surgeries a day and sees four to five patients per hour, in addition to performing various office procedures. His staff consists of two nurses and various clerical staff. On the examination/treatment side, the nurses do patient intakes and interviews, perform palliative care, and take x-rays. On the surgical center side, the nurses prepare the patients for surgery. Dr. Isham and those staff members who testified feel they strive to maintain a friendly and personal atmosphere for patients.

2.13 Dr. Isham is active in his church and the community. He provides free podiatric care to members of the clergy and provides care to the poor through a free clinic. One or more days a weeks, he sends his office nurses to Spokane area nursing homes to do nail care for the residents. Dr. Isham states his focal areas are his profession, his family, and his church.

2.14 In 1982, Dr. Isham purchased a pulsed infrared laser device called an Omniprobe IR. The device was marketed for use in promotion of wound healing.

treatments of ligaments, tendons and soft tissue, pain control, auriculotherapy and arthritis. It was classified as an investigational device by the United States Food and Drug Administration (FDA) and was not approved for therapeutic use. Dr. Isham used the device on post-surgical patients as an aid to healing. He did not charge a separate fee for the treatment and did not observe any adverse effect of its use. He discontinued use of the device in January or February 1994.

2.15 Dr. Isham states he has used a variety of methods for maintaining patient records. Early during his own practice, he developed a medical history form and a progress note form. His nurse would complete the medical history form when the patient arrived for the first appointment and would make any necessary additions on later visits. Dr. Isham also made notes on the medical history form. He contends his normal practice was to make all observations called for by the forms. If he made no entry in a particular area, Dr. Isham considered the findings to have been within the normal range.

2.16 The progress note forms were designed so procedures, conclusions, and recommendations could be circled. Dr. Isham did not have a form for surgical reports. Instead, he would indicate to his office manager what procedures had been done, the office manager would give the information to a typist, the typist would prepare a surgical report based on standard office procedures, and Dr. Isham would later sign the report.

2.17 Dr. Isham states that the patient record forms and procedures described in the preceding paragraph were designed to stimulate his memory. Using what he

terms "our standard practice," he believed he is able to recall the treatment provided and the condition of each patient. This is the case for the five patients whose care is at issue in the present proceeding. Dr. Isham has since developed new forms (see Exhibits 21 and 22) on which he writes diagnoses and procedures using a "SOAP" format.

2.18 Dr. Isham describes proposed surgical procedures to his patients at the time he recommends the procedure. He uses prepared anatomical drawings, traces outlines on the patient's x-rays, and/or draws on a board in the examination room, but does not record or save the devices used. The patient is permitted to ask questions. Generally, the surgery is scheduled for a later date. On the day of surgery, one of the nurses prepares the patient for surgery in the surgical room and provides an informed consent form for the patient to sign. The patient can ask more questions at that time if the patient desires to do so. The surgical consent form has been modified at various times. At some point, Dr. Isham also began having his surgical patients watch one or more videotapes prepared by Med Video Productions, Inc., prior to their surgery. The videotapes describe certain surgical procedures and provide general information. (Exhibit 19). Dr. Isham keeps no records of the questions asked by the patient, of whether or which videotapes were viewed, or who was present when the consent form was signed.

2.19 Four of the five patients, whose care is at issue in the present proceeding, have brought civil suits against Dr. Isham. He asserts that those suits and others are

being orchestrated by a single Spokane area attorney and that the concurrent litigation adversely affects the credibility of those patients in this proceeding.

2.20 Don Taylor has been a pharmacist in the Spokane area since 1950. He experienced foot pain associated with having to be on his feet all day. Corrective shoes did not relieve his symptoms and he sought correction of the problem from Dr. Isham in 1986. He was acquainted with Dr. Isham since his daughter is one of Dr. Isham's nurses. He wanted to get his foot "fixed no matter what it took" and had surgery on the day of his first appointment. Dr. Isham performed an osteotomy and ostectomy of the fifth metatarsal. Mr. Taylor returned to work the next day, wearing his hunting boots to accommodate the dressing. He was satisfied with the surgery and his recovery process.

2.21 Corinne Castle was referred to Dr. Isham by her sister in 1980. She had surgery for hammertoes on her right foot two days after her initial visit and had hammertoe surgery on her left foot a month later. She had three toes operated on again in 1987. She does recall signing one consent form on which certain information not been completed. She describes her recovery as good and is satisfied with the care she received.

2.22 Yvonne Hoffman was referred to Dr. Isham in 1986 by a co-worker who was also Dr. Isham's wife. Mrs. Hoffman had unsuccessful surgery for neuromas in 1974 and had used orthotics since 1980. Dr. Isham performed surgery for the neuromas in 1986, a bunionectomy in 1987, and three dorsal wedge osteotomies of the

metatarsals between 1989 and 1993. She states she understood bone would be cut during the osteotomies and that she was provided additional literature about the procedures when she requested it. Mrs. Hoffman now has no limits on the shoe styles she can wear. She considers Dr. Isham "accessible" and has referred others to him.

2.23 Patricia Haye was referred to Dr. Isham in 1987 or 1988 when she experienced pain on the outside and inside of her feet. She was interested in an early return to her active lifestyle as a landscape designer and race walker and had been told Dr. Isham's patients did not receive casts or other restrictive measures. She had a total of three surgeries: bilateral bunions and a bunionette or Taylor's bunion. She states she was given written post-operative instructions and knew that some limitations and cautions were appropriate after each surgery. She now wears casual shoes and orthotics. She is satisfied with the care she received. She has referred her husband and her daughter to Dr. Isham.

2.24 The care provided by Dr. Isham to five patients is at issue in this proceeding. Drs. Miller, Morton, and Weissman reviewed the care records for these patients as expert witnesses for the parties. In addition, Dr. Weissman had various conversations with Dr. Isham regarding his office procedures and his unwritten recollections of the patients. Drs. Miller and Morton, testifying for the Department, found Dr. Isham's care not sufficiently documented and substandard. Dr. Weissman, testifying for Dr. Isham, found Dr. Isham's care not sufficiently documented but believes the care was appropriate and within the applicable standard of care. Dr. Weissman

states that the care Dr. Isham provided to Mrs. Winship was at the outer limit of acceptable.

Patient Gadd

2.25 Leona Mary "Sunny" Gadd was a 52-year-old secretary when she first saw Dr. Isham. Mrs. Gadd had a history of foot problems and treatment including a bunionectomy and surgical removal of a neuroma on her right foot in 1972 or 1973. She wore a cast and experienced pain and swelling following that surgery. The bunion and neuroma pain returned and she developed a bunionette (Taylor's bunion) on the right foot. She had obtained orthotics from an orthopedic surgeon but achieved only partial short-term relief. After consulting other providers and getting a reference from two friends, she had her first appointment with Dr. Isham on June 12, 1987.

2.26 At the initial visit, Mrs. Gadd presented with symptoms of the right foot. Mrs. Gadd contends that her right foot was uncomfortable and that her left foot was asymptotic. Bilateral x-rays were taken. Dr. Isham determined that Mrs. Gadd had a "D-type foot with marked forefoot pathology," by which he meant she had biplanar splaying of the marginal metatarsals with the first and fifth metatarsals displaced above and outside the normal position.

2.27 Dr. Isham recommended surgical correction of Mrs. Gadd's condition using minimal incision surgery on both feet. Alternative treatment was not discussed because of Mrs. Gadd's prior experience with surgery and with orthotics and because she felt confident and enthusiastic about the proposed surgery. She understood that a

wedge of bone would be removed but did not understand that any bone would be cut completely through. She liked the idea that she would be ambulatory immediately following surgery.

2.28 Mrs. Gadd's first surgery was performed on July 13, 1987, on her right foot. While sitting in the surgical chair that day, she signed a surgical consent form authorizing "surgical correction of bunion and low 2,3 metatarsal bones right foot by the cutting and removal of bone." The operative report for the July 13, 1987, surgery includes preoperative diagnoses of "Hammertoe 1st Digit Right" and "Contracted 1st Digit Right" and describes procedures to correct those conditions.

2.29 Mrs. Gadd returned for follow up care on July 15, 20, and 24, and August 3. X-rays were taken on July 15. On each occasion, Dr. Isham circled the entry "healing as anticipated" or made no progress entry. Feldene was prescribed for swelling on one visit and laser treatments were provided on three occasions.

2.30 Mrs. Gadd's second surgery took place on August 7, 1987, on her left foot. Dr. Isham felt that the right foot was healing properly and states that Mrs. Gadd wanted the second surgery done at that time. Dr. Isham states that circles on the x-rays of June 1987 show that he observed calluses on Mrs. Gadd's left foot but did not chart them. Mrs. Gadd understood that the surgery would be similar to the first and signed a consent form while seated in the operating chair. The consent form described "surgical correction of bunion & low 2nd metatarsal left foot by the cutting and removal of bony tissue." The operative report again included diagnoses of hammertoe and

contracted first digit and surgical corrective procedures. Dr. Isham now states that the operative report was incorrect in that the first metatarsal was not plantarflexed and Mrs. Gadd did not have a hammertoe. He admits he did not review the operative report and states that it was prepared based on the standard office procedures.

2.31 Mrs. Gadd returned for various post-operative visits following her two s[illegible]eries. Dr. Isham's progress notes described "healing as anticipated." On September 23, 1987, a neuroma was noted and a preoperative consultation was conducted. Dr. Isham states that Mrs. Gadd was then complaining of pain under the fourth and fifth metatarsals and Taylor's bunion symptoms of her right foot. Dr. Isham felt that adequate time had elapsed since the July surgery to permit him to evaluate the need for additional surgery. He recommended surgery.

2.32 Mrs. Gadd returned for additional surgery on her right foot on September 25, 1987. Her husband accompanied her to the surgery and talked with Dr. Isham about her condition. Mrs. Gadd signed a consent form while in the operating chair for "surgical correction of Taylor's bunion & low 4th metatarsal bone right foot by cutting and removal of bony tissue." Again she understood that wedges of bone would be removed and did not understand that bones would be cut completely through. The operative report recorded preoperative diagnoses of "plantarflexed 4th and 5th Metatarsals Right" and "exostosis 5th Digit Right" and described surgical procedures for the correction of those conditions.

2.33 Mrs. Gadd experienced continuing pain and returned for surgery on her right foot again on November 11, 1987. This time she signed a consent form for "surgical removal of neuroma 3rd metatarsal area right foot by the cutting and removal of nerve growth." The operative report records preoperative diagnosis of "Neuroma Foot 2nd and 3rd Right" and describes excision of a neurofibrous mass from between the second and third metatarsals.

2.34 Mrs. Gadd experienced continuing problems with her feet. She returned for additional surgery on her left foot on March 30, 1988. She signed a consent form for "surgical correction of low 3rd & 4th metatarsal bones & exploratory neuroma surgery left foot by the cutting of bone." The operative report recorded preoperative diagnoses of "plantarflexed 3rd and 4th metatarsals left" and "neuroma foot 3rd Interspace left" and described surgical procedures to correct those conditions.

2.35 Following each of her five surgeries, Mrs. Gadd experienced swelling and some discomfort. She returned for post-operative visits. X-rays were taken on certain occasions. Her progress was repeatedly described as "healing as anticipated." She was given laser treatments on approximately eight of those visits. She understood the laser treatment to be conducive to healing.

2.36 Mrs. Gadd experienced continuing foot pain and deformity following her five surgeries. She had to purchase special shoes. Her foot width increased from a B/C to a D/E. She subsequently saw Dr. Daniele, another podiatrist, and Dr. Grainger, an orthopedic surgeon. Eventually she was referred to Dr. Hansen in Seattle.

2.37 Dr. Hansen determined that, as to her right foot, Mrs. Gadd's problems resulted from the fact that her first metatarsal was not weight bearing because it was hypermobile and too short following Dr. Isham's surgery. Dr. Hansen operated on her right foot in January 1990 using traditional surgical techniques including internal fixation with screws and casting. Mrs. Gadd received post-operative care from Dr. Peterson in S ıe and participated in physical therapy. Her recovery took 4 to 6 months. Mrs. Gadd now experiences no problems with her right foot.

2.38 Mrs. Gadd has continuing discomfort and deformation of her left foot. Dr. Hansen feels that corrective/reconstructive surgery may be of benefit. Mrs. Gadd has not scheduled the surgery.

Patient Winship

2.39 Jean Winship is a licensed practical nurse (LPN) and had been licensed since 1957. In 1987, Mrs. Winship began a new job as charge nurse at a nursing home. Her duties there included direct patient care and passing medications to long term care patients. She was 61 years old.

2.40 Mrs. Winship had served as a nurse in an obstetrics ward and other general nursing assignments, but had no professional experience with foot surgery. As a patient she had experienced several surgeries but none involving her feet.

2.41 For a period of time, Mrs. Winship had experienced foot pain after eight hours on her feet, a condition she described as 'nurse's feet." She testified she had no

problem with her calluses. Her foot pain became a problem for her in her new position. She had had no prior professional foot care and was referred to Dr. Isham by a friend.

2.42 Mrs. Winship first saw Dr. Isham on October 14, 1987. Dr. Isham examined Mrs. Winship and x-rays were taken. Dr. Isham determined she had a "type C" foot (dorsal splaying of the marginal metatarsals) and said he could help by surgical intervention on both feet. Mrs. Winship testified no alternative treatments were discussed. Dr. Isham states he remembers discussing orthotics and palliative care of her calluses.

2.43 Mrs. Winship made and kept an appointment for the surgery on October 21, 1987, a Wednesday. She signed a consent form presented to her by an assistant while in the reception area. Based on the information provided to her, Mrs. Winship believed she would be able to walk out of the surgery and return to work on the following Monday. She understood she would have surgical shoes and surgical bandaging, but believed she would have no restrictions on ambulating. Returning to work promptly was important to her because she had just started a new position. She also anticipated a vacation trip to Hawaii in December. She testified Dr. Isham told her she would have no problem with either activity.

2.44 Dr. Isham contends that his assessment was based in part on Mrs. Winship's representation to him that she could and would use a wheelchair at work. He did not record this consideration in the records. Mrs. Winship testified that no

discussion of wheelchair use occurred until approximately a year later when she wanted to use one at the county fair.

2.45 On October 21, 1987, the scheduled day of surgery, Dr. Isham agreed to proceed with the surgery on both feet. He says he did so at the insistence of Mrs. Winship who wished to minimize her recovery period and take advantage of her upcoming vacation for recovery. Dr. Isham had no special concerns about the bilateral surgery that was undertaken. The surgery consisted of dorsal wedge osteotomies of the second, third, and fourth metatarsals of both feet.

2.46 When Mrs. Winship returned for follow-up care on October 23, 1987, x-rays were taken. Those x-rays show the severed second, third, and fourth metatarsals of the left foot completely out of alignment and the severed second and fourth metatarsals of the right foot greatly displaced. Dr. Isham recorded that Mrs. Winship was "healing as anticipated" and provided a laser treatment. He wrote a note to Mrs. Winship's employer requesting that she be excused from work on October 24 and 25, and permitted to work to tolerance from October 26 through 31. He not otherwise alter the post-operative care regime being provided to Mrs. Winship.

2.47 Mrs. Winship also returned for follow-up care on November 11 and 16, 1987. She received orthotics on November 16 and laser treatments on both occasions. On November 16, Dr. Isham recorded "healing as anticipated."

////////////////////////////////

////////////////////////////////

2.48 Mrs. Winship found herself unable to complete her shifts at work and filed for disability insurance. Mrs. Winship did go on her Hawaii vacation. She reports her feet were very sore during the trip.

2.49 Mrs. Winship returned for follow-up care on January 4 and 13, February 12, and March 3. Dr. Isham's records show Mrs. Winship experienced ongoing problems with swelling and pain and that he adjusted her orthotics and prescribed Feldene and injected Dalalone. No other changes were made in the post-operative routine and no other x-rays were taken.

2.50 On March 16, 1988, Dr. Isham advised Mrs. Winship she had an exostosis of the first digit right. Mrs. Winship understood she had a "spur" which was causing calluses. Dr. Isham suggested surgical removal of the spur and Mrs. Winship agreed.

2.51 Mrs. Winship returned for surgery on March 18, 1988. She signed a consent form for "surgical correction of hammertoe first digit bilateral by the cutting and removal of bone." Dr. Isham's operative report describes the removal of an exostosis of the first digits bilateral. Dr. Isham explains the discrepancies in these records by the fact that the consent form was prepared by and presented to Mrs. Winship by a podiatry resident.

2.52 Mrs. Winship returned for follow-up care on March 21, 1988. X-rays were taken of both feet at that time, a laser treatment was provided, and Dr. Isham recorded "healing as anticipated." The x-rays show significant gaps between the sections of the

second, third, and fourth metatarsals of both feet and diminishing bone density in the distal fragments. Dr. Isham did not alter the post-operative regime.

2.53 Mrs. Winship experienced continued swelling. Dr. Isham recorded swelling on March 28, 1988, and injected Dalalone on April 6, 1988. No other treatment was provided for the misaligned metatarsal fragments.

2.54 During early June 1988, Mrs. Winship fell off a bicycle. She had purchased the bicycle to help her get about near a summer home because she could not walk comfortably. She asserts she fell because her foot would not support her. That same month, she quit her job at the nursing home due to neck, back, and foot pain.

2.55 Mrs. Winship returned to Dr. Isham on June 24, 1988, for an orthotic check. On August 26, 1988, Mrs. Winship was again examined and x-rays taken. Those x-rays show gaps between the fragments of all six metatarsals. Dr. Isham provided an injection for edema and noted delayed healing. He did nothing to reduce the gaps or align the bone fragments.

2.56 On September 2, 1988, a progress note records delayed union of the involved metatarsals possibly due to parathyroid function, very restricted activity, and an intention to apply casts. Casting was considered only at Mrs. Winship's request. Mrs. Winship's left foot was casted on September 23, 1988. X-rays were taken through the cast on October 14 and the cast was removed on October 21. The right foot was later casted and that cast was removed on November 11. Bilateral x-rays were taken

on November 28. Those x-rays show incomplete healing of all six metatarsals and continued misalignment of several of the segments. On December 12, 1988, 14 months after her first surgery, Mrs. Winship described her feet as getting back to normal.

2.57 In May 1989, Mrs. Winship was referred to Dr. Hansen. At his recommendation, she had additional surgery in June 1989 to realign the metatarsals of the right foot. She is now reasonably comfortable.

Patient Wiltshire

2.58 Kimberly (Coleman) Wiltshire has held a variety of positions as a waitress and in insurance claims processing. She enjoys athletics, including walking, running, and volleyball. She had been walking 5 to 7 miles a day. Prior to her experiences with Dr. Isham, she had had no professional foot care. She was 22 years old.

2.59 At some point prior to her first visit to Dr. Isham, Ms. Wiltshire injured her left foot playing volleyball. She then experienced foot pain under the ball of her foot which was worse when walking. She was referred to Dr. Isham by a co-worker.

2.60 Ms. Wiltshire first saw Dr. Isham in June 1988. Ms. Wiltshire testified that her appointment was 1 to 2 weeks after her injury and that she told Dr. Isham about the volleyball injury as well as the pain she was experiencing. Dr. Isham testified Ms. Wiltshire reported the pain but did not mention the injury. His chart records describe a gradual increase of pain and a painful bunion. X-rays were taken on that first visit.

2.61 Dr. Isham determined that Ms. Wiltshire had a bunion condition and recommended surgical correction. Mrs. Wiltshire understood that a nick would be taken out of the bones of the first toe by minimal incision surgery, that she could walk out of the surgery, that she would have some pain and swelling during a recovery period during which she would use a surgical shoe, and that "at worst, the condition would get better." In later professional correspondence (letter to Dr. Morton, dated December 17, 1990), Dr. Isham described Ms. Wiltshire's condition as "a painful left hallux abducto valgus associated with a forefoot valgus-type foot structure."

2.62 On June 17, 1988, Ms. Wiltshire signed a surgical consent form authorizing "surgical correction of bunion left foot by the cutting and removal of bone." Dr. Isham's operative report contains a diagnosis of hallux valgus left, hammertoe 1st digit left, and contracted 2nd digit left. The report records that the following procedures were performed: Reverdin-Isham bunionectomy, osteotomy proximal phalanx base 1st digit left, and arthrotomy 2nd digit left. Dr. Isham admits these records are incorrect in that Ms. Wiltshire did not have a hammertoe condition, that the surgical procedure on first toe was part of the bunionectomy, and that the contracted second digit was an intra-operative diagnosis.

2.63 Ms. Wiltshire describes her recovery as slow and continuing to the middle or end of September. She began to experience significant pain under her left tibial sesamoid bone. She used orthotics without relief and confined her activity to

low-impact aerobics. She had several follow-up care visits, including at least three laser treatments.

2.64 During a September 14, 1990 visit, Dr. Isham took new x-rays and determined that Ms. Wiltshire's continuing pain was due to pressure under the sesamoid bone. He recorded "painful L medial ball of foot." Dr. Isham does not remember if he reviewed the original (June 1988) x-rays at this time or whether he recognized or diagnosed the bipartite condition of Mrs. Wiltshire's sesamoid bone at any time. He proposed surgical intervention to thin the sesamoid bone, which lies on the lower aspect of the great toe joint (MP joint). Ms. Wiltshire understood that bone had built up on the side of her foot and that bone would be planed off the side of her foot. On September 21, 1990, she signed a surgical consent form for 'surgical correction of thick bone" and Dr. Isham performed a sesamoid planing.

2.65 Ms. Wiltshire again had several post-surgical appointments during which she reported a great deal of pain. She received one laser treatment.

2.66 Ms. Wiltshire's pain was not reduced by the planing procedure. She was still in pain during her November wedding and honeymoon.

2.67 In December 1990, Ms. Wiltshire saw David Morton, D.P.M., regarding her condition. Dr. Morton concluded that Ms. Wiltshire's current pain was due to a lack of great toe purchase resulting from a dorsiflexed position of the capital fragment of the first metatarsal. He questioned whether the flexor hallucis brevis tendon and/or longus muscles had been compromised during the sesamoid planing procedure. Dr. Morton

referred Ms. Wiltshire to Dr. Zirm for another opinion and also sought consultation from his colleagues at a local podiatric hospital and a podiatric conference. The consensus was that the elevated first toe was the cause of the pain and that surgical correction was necessary.

2.68 Ms. Wiltshire declined further surgery by Dr. Isham. She delayed any ...onal surgery for family obligations. In April 1993, R. J. Zirm, D.P.M., performed a repair of the hallux malleus with tendon transfers and capsular release on her left foot. He found that the tendons had, in fact, been compromised at some earlier date. Ms. Wiltshire experienced relief from her pain and remains under Dr. Zirm's care. A fourth operation is anticipated.

2.69 Based on the original x-rays (June 1988), Drs. Morton, Zirm, and Miller would have diagnosed a fractured sesamoid bone and would not have diagnosed a bunion condition. None of the doctors recall whether they knew of the volleyball injury at the time they reached that conclusion.

2.70 Dr. Weissman testified that half of all patients have bipartite sesamoid ...es either congenitally or because of injury. Dr. Weissman suggests that, without knowledge of the volleyball injury, Dr. Isham could reasonably have overlooked the possibility of a fracture. Dr. Weissman also testified that, with knowledge of the volleyball injury, the fracture diagnosis was more appropriate than the bunion diagnosis.

2.71 Dr. Isham asserts that he considered the possibility of a sesamoid fracture at the June 1988 visit but that, without knowledge of an injury, he concluded that

sesamoid was naturally bipartite and that the bunion condition was the source of Ms. Wiltshire's pain. He made no record of his consideration. He asserts he would have discussed the alternative diagnosis with the patient because that was his standard practice.

Patient Mueller

2.72 Pamela Mueller is a public school teacher. She is married to a pedodontist (dentist for children). Prior to her experiences with Dr. Isham, she had received no professional foot care. Mrs. Mueller has been active in sports and enjoyed running and walking. She stopped running about 1986 due to foot discomfort but continued walking an hour at a time without discomfort. She believed she had bunions and wanted to prevent worsening of her condition. She was referred to Dr. Isham by a friend. She was 44 years old.

2.73 Mrs. Mueller first saw Dr. Isham on August 2, 1989. Dr. Isham examined her feet and took x-rays. According to the billing he submitted to Mrs. Mueller's insurance carrier, he determined she did have bilateral bunions and that her second metatarsals were proportionately too long. He recommended surgical correction of both conditions.

2.74 Based on her conversation with Dr. Isham, Mrs. Mueller understood that the surgery would be "easy" and would require a 6 to 8 week recovery period. She understood that without surgical correction, her condition would worsen and would cause additional problems such as calluses, difficulty in walking, and shoe trouble. She

understood that her bunion would be "cut off" with a drill and that a tendon would be cut. She did not understand that any other bone would be cut.

2.75 Mrs. Mueller appeared for surgery on November 11, 1989. When seated in the surgical chair, she signed a consent for "surgical correction of bunion & low 2nd metatarsal bone left foot." Dr. Isham's surgical report describes correction of the bunion by a Reverdin-Isham bunionectomy, correction of a plantarflexed second metatarsal by a dorsal wedge osteotomy, and correction of a hammertoe by a CAPP procedure. Mrs. Mueller was sent home from the surgery in a surgical wrap and a surgical shoe with instructions to stay off her foot for a period of time.

2.76 Drs. Miller and Weissman testified that Mrs. Mueller had received a bunionectomy and an osteotomy of the second metatarsal but not a hammertoe procedure. Dr. Isham now states that he performed an Akin procedure as part of the bunionectomy but did not perform a hammertoe procedure.

2.77 Mrs. Mueller saw Dr. Isham for follow-up care at least 14 times between November 29, 1989 and March 15, 1991. Laser treatments were provided on the first four post-operative visits. On the fifth visit, January 12, 1990, Feldene was dispensed and orthotics were fabricated. X-rays were taken on November 29, 1989, and February 9, 1990.

2.78 Mrs. Mueller experienced pain during the recovery period and states she reported the pain to Dr. Isham. The orthotics also caused pain. She experienced continuing problems and discomfort. She states she began experiencing pain on the

outside of her foot, that the bunion returned within a year, and that her toe did not "go straight." She experiences pain when she walks to excess and when she wears heeled shoes.

2.79 At some point during early 1990, Mrs. Mueller's physician referred her to Alan Danielson, M.D. for review of her foot condition. Dr. Danielson examined her, and found chronic stiffness about the MP joint and the second toe. He suggested padding and comfortable sport shoes, and advised against further surgical intervention.

2.80 Mrs. Mueller saw Dr. Isham on February 15, 1992, for what Dr. Isham recorded as "Consultation Big Time." He recorded that "success" was "late," that he found possible problems, and that Mrs. Mueller should decide by her symptoms whether she needed additional surgery. At hearing he stated he meant healing was late.

2.81 On February 27, 1992, Mrs. Mueller returned to Dr. Danielson. Dr. Danielson found her condition basically unchanged and recorded that Mrs. Mueller was having difficulty regaining activity. He again recommended against additional surgery and told Mrs. Mueller he would not have performed the first bunion surgery because she was not symptomatic at the time.

2.82 Mrs. Mueller stopped seeing Dr. Isham after March 1991 because she felt Dr. Isham had been ineffective. Dr. Isham states he believes Mrs. Mueller experienced a less successful result than she had expected and that she is unhappy despite his

efforts to communicate during the "consultation" appointments. He states "there are some people you can't communicate with."

Patient Gushalak

2.83 Vera Gushalak was a 62 two-year-old woman when she first saw Dr. Isham on September 13, 1991. Mrs. Gushalak lived at Oakhill Home in Spokane. had lived in supervised settings for many years. She has been diagnosed as bipolar manic depressive with psychotic features. Thomas Osten, M.D. is her physician and had provided care to her for several years. However, Dr. Osten had provided no foot care to her.

2.84 On September 13, 1991, Mrs. Gushalak came to Dr. Isham's office for care of painful corns and calluses on her feet. This visit was at the urging of the staff of Oakhill Home. Dr. Isham took x-rays and performed an examination. At that time Dr. Isham identified one or more plantarflexed metatarsals, as well as decubitus ulcers associated with the corns. Dr. Isham and his staff provided palliative care and Mrs. Gushalak was casted for orthotics. Her orthotics were dispensed on October 4, 1991.

2.85 Mrs. Gushalak returned to Dr. Isham's office on February 26, 1992. Once again she was complaining of painful corns and calluses. By this time, Dr. Isham was using a "SOAP" format for recording physicians notes. His records show that he found severe hyperkerototic lesions with subdermal bleeding and ulceration. He also diagnosed a hammertoe condition and plantarflexed metatarsals on both feet. No new

x-rays were taken. Dr. Isham testified he did not think there had been enough change to warrant new x-rays. However, Dr. Isham recorded that the x-rays confirmed his (current) diagnosis.

2.86 According to Dr. Isham's physician notes, he determined that he should operate immediately in light of the acute nature of the condition. He noted that he would not be reimbursed for the surgery by Mrs. Gushalak's medical insurance but that he would film the surgery for an upcoming presentation in Madrid. At hearing, he testified that he had suggested another appointment but that Mrs. Gushalak's companion had urged doing the surgery the same day since Mrs. Gushalak was already there.

2.87 The staff explained the surgical procedures to Mrs. Gushalak's companion. However, the companion declined to sign the consent form and said Mrs. Gushalak signed her own papers. Without providing additional explanation, the form was given to Mrs. Gushalak. She signed a surgical consent form authorizing "surgical correction of low 2nd & 3rd metatarsal bones right foot and low 5th metatarsal bones and 2nd hammertoe (spurs) left foot. Surgical correction of 5th hammertoe right foot."

2.88 The surgery was performed and videotapes were made of portions of the surgery. 65 minutes after administration of the anesthetic began, Mrs. Gushalak was released to her own custody with post-operative instructions. Both feet were bandaged. She was instructed to return in two days. She described the surgery as, "He dug

around my feet for a while, sewed them up and let me go." No attempt was made to contact Mrs. Gushalak's residential care givers or her physician regarding the surgery performed or the post-operative care recommended. Dr. Isham prepared a "corrected" surgical report on March 4, 1992. There is no evidence concerning the original surgical report or the nature of the corrections made.

2.89 On February 27, 1992, the day following her surgery, Mrs. Gushalak fell and injured her right knee while walking about the icy grounds of the Oakhill Home. She was taken to Dr. Osten on February 28. Before taking her there, the Oakhill staff called Dr. Isham and canceled Mrs. Gushalak's appointment.

2.90 Dr. Osten removed the compression bandages applied by Dr. Isham and discovered multiple incisions with stitches on her toes. He observed her feet to be swollen and noted that her calluses had not been removed and her nails had not been trimmed. According to Mrs. Gushalak, Dr. Osten's reaction was "Good God, all that to remove calluses." Dr. Osten recommended that Mrs. Gushalak not return to Dr. Isham and determined to take over Mrs. Gushalak's post-operative care.

2.91 Later that day, the Oakhill staff called Dr. Isham's office again. During the conversation, the caregiver stated that Dr. Osten was disturbed about the surgery and that Mrs. Gushalak was upset after seeing Dr. Osten.

2.92 On May 4, 1992, Marci Faso, Dr. Isham's secretary/receptionist made a written record of the two telephone conversations with the Oakhill staff.

2.93 Dr. Osten saw Mrs. Gushalak on March 2, 9, and 13, 1992, for post-operative care. On March 2, he prescribed antibiotics. On March 9, he removed corns and calluses and opened some pus pockets on her feet. On March 13, he took x-rays and discovered the "broken" metatarsal bones. He has continued to trim Mrs. Gushalak's corns and calluses every three to four months.

III. SECOND REVISED CONCLUSIONS OF LAW

3.1 Dr. Isham is licensed to practice as a podiatric physician and surgeon in the state of Washington. He is subject to the provisions of chapters 18.22 and 18.130 RCW and chapter 246-922 WAC.

All Patients

3.2 The Board recognizes that good results do not always follow from surgeries properly performed. Accordingly, not all bad surgical results are indicative of improper diagnosis, poor surgical technique, or any other shortcoming of the physician. Accordingly, the Board declines to find that a poor surgical outcome alone constitutes negligence, malpractice, or incompetence in violation of RCW 18.130.180(4).

3.3 Some of the patients involved in this matter have filed civil suit against Dr. Isham. Dr. Isham suggests this circumstance affects the credibility of the patients and the accuracy of their testimony. The Board finds the testimony of the patients consistent with Dr. Isham's patient records, insofar as the records are complete. The patients have all taken oaths of truthfulness. Dr. Isham has shown no aspect of the

patient testimony to be unduly inaccurate or suspect for motive. Accordingly, the Board finds that the existence of concurrent civil litigation has no impact on the present matter.

3.4 Dr. Isham does have satisfied patients. Some of them have testified in the present matter. These patients had good results from basically the same types of surgery for the same podiatric conditions as the patients here at issue. These patients rienced essentially the same regime of pre-, intra-, and post-operative care. However, the Board finds that the care provided by Dr. Isham to each individual patient must be measured against the applicable standard of care. The testimony of those satisfied patients affirms certain aspects of the routine of care described by Dr. Isham himself. However, the quality of care provided to one patient does not guarantee that the same quality of care was provided to any other patient. Each patient's care must be individually planned and assessed. Accordingly, the Board finds that the testimony of the satisfied patients is not relevant to the alleged violations but may be relevant to the appropriate sanction, if any.

3.5 Various other practitioners provided opinions and/or testimony about the care provided to the patients by Dr. Isham. In particular, Drs. Miller, Morton, and ..ansen testified as witnesses for the Department of Health. Dr. Weissman testified for Dr. Isham. These witnesses are experts in their fields. The Board finds each of them credible and to have conducted a reasonably thorough review of the records. Each arrived at conclusions based on the totality of the records and testified predictably in support of the position of the party for whom they testified. However, the Board may

exercise its own professional expertise in reviewing the analysis and opinions of these expert witnesses. RCW 34.05.461(5). The Board chooses to do so.

3.6 Dr. Isham practices minimal incision surgery and adheres to the practices of external fixation and rapid ambulation espoused by proponents of minimal incision surgery. He is among the few podiatrists to do so in Washington. The record in this case clearly demonstrates and supports Dr. Isham's contention that minimal incision surgery is not universally accepted by practitioners in this state. The Board recognizes that minimal incision surgery is a recognized method of surgery, supported by national organizations, based on scientific studies and expertise, and not prohibited by the standards of practice in Washington. Dr. Isham contends his selection of minimal incision surgical techniques subjects him to a standard of care different from that applicable to podiatrists who do not practice minimal incision surgery. The Board rejects that contention. While the Board draws no conclusion from Dr. Isham's professional preference for minimal incision surgery nor from the rejection of the technique by other practitioners, it does find that each podiatric physician and surgeon in the state of Washington is responsible for selecting appropriate treatment modalities from the array of modalities available and for implementing those modalities with appropriate skill and safety. All other podiatric physicians and surgeons in the state of Washington, including Dr. Isham, must meet this standard of care.

3.7 The Department of Health contends that Dr. Isham did not obtain fully informed consent from his patients because he used the term "nick" of bone in

describing to the patients the osteotomy surgery that was to be performed. Dr. Isham also used various diagrams to describe the surgery. In each case, it is clear that he described removal of a wedge-shaped piece of bone during the osteotomy and tried to do so in lay terms. It is not clear that he indicated that there would, necessarily, be a hinge or unsevered portion of the bone left unsevered. There is no evidence to suggest that the patients would have reached a different result in their decision to authorize surgery or that they would have understood a different post-surgical regime was appropriate had they known a through-and-through osteotomy might result. Informed consent means the patient has been provided a reasonable opportunity to understand the nature of the surgery but does not mean the patient must attain a full technical understanding of the surgery. Consequently, the Board finds that Dr. Isham's use of the term "nick" of bone when a through-and-through osteotomy was possible or even likely to occur does not constitute lack of informed consent.

3.8 Dr. Isham purchased an Omniprobe IR device and repeatedly used it to provide pulsed IR laser treatments to his patients. Dr. Isham admits that the Omniprobe device was classified an experimental device by the United States Food and Drug Administration at the time he used the device. 21 CFR Part 812 provides that such devices may be used in experimental situations subject to certain conditions including a prohibition against representing that the device is safe or effective, following an organized and monitored investigational project, and maintenance of records.

Dr. Isham did none of these. Each use by Dr. Isham of the Omniprobe on a patient is in violation of 21 CFR Part 812, and is a violation of RCW 18.130.180(7).

3.9 Dr. Isham did not charge his patients any additional fee for application of the Omniprobe. Consequently, his use of the Omniprobe does not constitute promotion for personal gain and is not a violation of RCW 18.130.180(16).

Patient Gadd

3.10 Mrs. Gadd underwent five surgeries with Dr. Isham. Her first surgery (on her right foot) was performed on July 13, 1987. Her third surgery (second surgery on her right foot) was performed on September 25, 1987, approximately 10-1/2 weeks later. Her first surgery involved surgical correction of the first, second, and third metatarsals of her right foot. Her third surgery involved surgical correction of the fourth and fifth metatarsals of her right foot. She had been told they also required surgical correction and she signed a consent form. Dr. Isham notes that she had the opportunity to ask questions and that her husband accompanied her to the third surgery and asked questions. The diagnosis presented to the Gadds was a deformity of the fourth and fifth metatarsals. Neither Mrs. Gadd nor her husband had training in foot physiology or podiatry. Based on the diagnosis presented to them and with the knowledge each possessed, Mrs. Gadd consented to the third surgery.

3.11 The various podiatrist witnesses gave various estimates of the time required for healing following podiatric surgery. The lowest estimate was Dr. Isham's own estimate of 6 to 8 weeks as an average. He testified that substantial union would

usually occur by that time. Full healing would, therefore, take longer. Mrs. Gadd was just beyond the "average" healing period. Dr. Isham contends that he routinely monitored post-surgical progress using the Lixiscope. He does not know if he used the Lixiscope on Mrs. Gadd, but he did determine that Mrs. Gadd was ready for additional surgery. He did not take x-rays until after the third surgery. Whether or not Dr. Isham dered the implication of the fact that Mrs. Gadd was just beyond the "normal" healing period, he did not inform Mrs. Gadd of the reasonable possibility that she was healing somewhat more slowly than the average. He should have considered this and should have informed Mrs. Gadd of the possibility.

3.12 Dr. Isham did take x-rays of Mrs. Gadd's right foot on September 28, 1987, three days after surgery. Those x-rays show the recent osteotomies of the fourth and fifth metatarsals. They also show substantially incomplete healing of the first and third metatarsals, with significant lack of bone density still showing in the inter-fragment areas. The second metatarsal shows significantly more healing. Therefore, the medial aspect of the foot was still unstable. Although Dr. Isham cannot be held to knowing on September 25 the extent of the incomplete healing which appears in the x-rays of September 28, he did have a duty to accurately assess Mrs. Gadd's condition. By whatever means, he assessed her sufficiently healed to withstand and warrant surgery on the two previously uninvolved metatarsals.

3.13 Weight transfer is a common occurrence during post-surgical periods. Such compensation is potentially present in all post-surgical patients. A likely cause of

Mrs. Gadd's pain on the outer aspects of her foot was weight transfer from the inner to the outer foot to compensate for the instability still remaining from the first surgery. This phenomenon is highly likely in light of the destabilization of three of the five metatarsals of Mrs. Gadd's right foot, especially considering that the great toe normally bears substantially more than its share of weight. Dr. Isham did not inform Mrs. Gadd of even a possibility that her outer foot pain was the ongoing result of her first surgery and that she could wait to see if the pain resolved itself when additional healing occurred. She should have been informed of this significant option.

3.14 The Board finds that Mrs. Gadd should have been informed of the matters described in paragraphs 3.11, 3.12, and 3.13 above. Without that information, Mrs. Gadd could not make an informed consent regarding her care. Neither Mrs. Gadd nor her husband could be expected to ask about partial healing and/or weight transfer. By failing to inform Mrs. Gadd, Dr. Isham misrepresented her condition and the reasons for the surgery. He should have considered alternative explanations of her condition and did not do so and/or did not inform Mrs. Gadd. He was negligent in having failed to do so. Dr. Isham has violated RCW 18.130.180(4), and (13).

3.15 Dr. Isham provided laser treatments to Mrs. Gadd on at least eight occasions or caused such laser treatments to be provided. He has violated RCW 18.130.180(7).

////////////////////////////////

////////////////////////////////

Patient Winship

3.16 Mrs. Winship was a nurse. Dr. Isham appears to contend that her occupation should have given her additional knowledge and understanding of the disability she could experience after her surgery. However, Mrs. Winship had no experience with surgical nursing. Dr. Isham's reliance on Mrs. Winship's knowledge & ability to appropriately care for her feet was without basis. He had an obligation to provide specific instructions for post-operative care which he did not fulfill.

3.17 Mrs. Winship had just started a new job as a medication and treatment nurse in a nursing home. She was under some pressure to appear and perform her duties. Her routine duties required her to visit patient rooms throughout her shift and to do various tasks there. Dr. Isham represented to Mrs. Winship that she could do this. She believed him and tried to do so. Dr. Isham now contends that Mrs. Winship said she could use a wheelchair on the job. A reasonable inquiry into Mrs. Winship's responsibilities shows that some alternate form of mobility would have been necessary to facilitate full eight-hour shifts immediately after surgery involving the entire mid-foot. should not merely "walk to tolerance." She was expected to ambulate for eight hours. There is no record of any conversation about wheelchair use. Dr. Isham contends that he notes only those matters which are unusual and do comport with "our routine." Mrs. Winship's situation was hardly routine. Accordingly, the Board finds that the conversation did not occur. Dr. Isham's misrepresentation of Mrs. Winship's ability

to return to work immediately after surgery constitutes misrepresentation. He has violated RCW 18.130.180(13).

3.18 While Dr. Isham may have suggested that Mrs. Winship schedule surgery on her two feet on different occasions, he acceded to her request to operate on both feet at the same time. He testified that he had done so solely because Mrs. Winship wanted it that way. Despite some asserted reservations about bilateral surgery, Dr. Isham did not explain to Mrs. Winship that additional complications were possible when both feet were significantly destabilized simultaneously. In light of Mrs. Winship's occupational needs, the possibility of additional complications was significant. Mrs. Winship made her decision to have bilateral surgery without that information. Additionally, Dr. Isham did not ever inform Mrs. Winship of the degree to which the complications had, in fact, occurred. Despite repeated x-ray and manual examination, he continued to record "healing as anticipated" and to encourage Mrs. Winship to follow the "normal" post-operative regime. Dr. Isham's failure to adequately inform Mrs. Winship of the nature of the bilateral surgery and the possible complications, to consider Mrs. Winship's circumstances in his assessment of those risks, to advise Mrs. Winship of the complications that had occurred, and to encourage her to continue with an unaltered treatment plan, constitute negligence and malpractice in violation of RCW 18.130.180(4).

3.19 The surgery performed by Dr. Isham was to include wedge osteotomies of three metatarsals of each foot. Regardless of the intended depth of cut, there was a

significant risk that the wedges could completely transect the bone. Later x-rays suggest this did actually occur in most if not all of the metatarsals involved. Completely transected, the bones could not contribute to the stability of the foot. Additionally, Dr. Isham saw the results of surgery in the x-rays of October 23, 1987, including four metatarsals which were completely displaced. Dr. Isham states that it is his standard of to place the metatarsal sections in the optimal position for healing. They were not so placed and were clearly a poor surgical outcome. Nonetheless, Dr. Isham did not significantly adjust his post-operative care or instructions for this result. His post-surgical "routine" was still followed except that he did authorize two days off work. Apart from that, he continued to allow ambulation limited only by tolerance and without inquiry into Mrs. Winship's actual tolerance vis-à-vis her condition. He permitted Mrs. Winship to return to work after the two-day period. Dr. Isham's failure to adjust his treatment of Mrs. Winship in the face of clear evidence of a poor surgical result constitutes negligence and malpractice in violation of RCW 18.130.180(4).

3.20 Dr. Isham performed a second surgery on Mrs. Winship in March 1988, approximately 6 months after the first surgery. In the professional opinion of all the doctors testifying here, 6 months is an adequate healing period for the normal patient. Dr. Isham had x-ray evidence that Mrs. Winship was not healing as rapidly as normal. Her body was not rebuilding bony tissue at a normal pace. She was experiencing ongoing pain and swelling which required medicinal treatment by Dr. Isham during the weeks before the March surgery. By undertaking the additional surgery, Dr. Isham

determined that Mrs. Winship could undergo additional surgery and could produce the additional healing. This is not supported by Mrs. Winship's recorded objective condition or by her subjective condition. Under the circumstances, undertaking the March 1988 surgery constitutes negligence and malpractice in violation of RCW 18.130.180(4).

3.21 Dr. Isham provided laser treatments to Mrs. Winship. He has violated RCW 18.130.180(7).

Patient Wiltshire

3.22 Mrs. Wiltshire presented to Dr. Isham's office with foot pain. The accounts differ whether Mrs. Wiltshire told Dr. Isham about the volleyball injury. X-rays taken on the occasion of the first visit clearly show a divided sesamoid bone. In the professional expertise of the Board, the sclerotic condition of the sesamoid bone is not clearly indicative of either a very recent injury or of a sesamoid division of substantial duration. While in retrospect, it seems clear that there probably was a sesamoid fracture, Dr. Isham was faced with making diagnosis on the basis of information available to him. Without the information about a recent traumatic injury, Dr. Isham could have reasonably have decided against further x-rays to detect a fracture, and could have made the bunion pain diagnosis. Therefore, without clear proof that Dr. Isham did know about the injury, the Board declines to find that the diagnosis was beyond the standard of care.

3.23 Based on its professional expertise, the Board finds that there was significant bony formation evident in the area of the sesamoid bone by the time of the

September 1990 x-rays. This is consistent with healing of a fractured sesamoid or with healing of the metatarsal and may indicate immobilization of the sesamoid and nerve entrapment. However, without clear evidence that Dr. Isham did know of the volleyball injury and thereby the likelihood of sesamoid fracture, the Board declines to find the second (September 1990) diagnosis was beyond the standard of care.

ent Mueller

3.24 Mrs. Mueller sought preventative care for her feet. Except for some discomfort, she was largely asymptomatic. However, she understood that her condition was progressive and could deteriorate. After several months, she elected to have surgery. Her recovery from that surgery was not as rapid as she had expected nor as rapid as Dr. Isham had represented to her. However, the Board finds that there is no evidence that any delayed healing is due to the quality of the surgery performed by Dr. Isham.

3.25 Mrs. Mueller understood that surgery would be performed on her bunion and on her second metatarsal. She understood that bone would be operated upon with drill and that a tendon would be shortened. These are the essential elements of the surgery performed by Dr. Isham. Dr. Isham described to Mrs. Mueller the normal recovery period of 6 to 8 weeks. Mrs. Mueller signed a consent form in which she acknowledged that delayed healing might occur. Mrs. Mueller did, in fact, experience a recovery period somewhat longer than the norm. The February 9, 1990, x-rays, three months post-surgery, show substantial union of the bones. Her recovery period is

further made unclear by the fact that she was largely asymptomatic prior to the surgery. However, there is insufficient evidence to conclude Dr. Isham misrepresented the nature or result of the surgery to Mrs. Mueller.

3.26 On at least four occasions, Dr. Isham performed laser treatments or permitted them to be performed on Mrs. Mueller. He has violated RCW 18.130.180(7).

Patient Gushalak

3.27 Mrs. Gushalak did not always hear and/or respond appropriately to questions posed to her at hearing. The Board is unable to determine whether she is capable of understanding information provided to her or the seriousness of matters and situations. From the answers she gave at her deposition, it is clear that her confused communications are of some duration and not solely a product of nervousness at the hearing. However, the record in this case supports the conclusion that Mrs. Gushalak, however mentally competent, was legally competent to make her own decisions and to sign her own documents.

3.28 Mrs. Gushalak did consistently follow instructions given to her at hearing. She looked at the persons she was told to look at. She sat where she was directed and stood when told she could leave. Nonetheless, it is also clear that Dr. Isham and his staff recognized a communication problem with Mrs. Gushalak. They conducted their discussions with her caregiver and accepted the caregiver's decision to do the surgery immediately. They were surprised when the caregiver declined to sign the consent form and said Mrs. Gushalak would sign it. In light of the non-emergency nature of the

surgery and the communication questions, the Board finds that Dr. Isham had an obligation to verify Mrs. Gushalak's ability to understand the instructions given her and to consult with her other caregivers to assure she would receive proper post-operative care. He did not do so. His failure to do so constitutes negligence which created a risk that Mrs. Gushalak would be further injured. Dr. Isham has violated

V 18.130.180(4).

3.29 Dr. Isham testified that on February 26, 1992, he observed acute changes in Mrs. Gushalak's calluses and that he recognized there was an substantial risk of ulceration occurring if it had not already occurred. In the professional opinion of the Board and the opinion of the experts at hearing, surgery in the presence of an ulcerative condition creates substantial risk to the patient. Nonetheless, Dr. Isham determined that elective surgery should be done as soon as possible and recorded that he decided to do so immediately despite the likelihood of no financial recovery of costs. He now states he urged Mrs. Gushalak's caregiver to make a later appointment. His current explanation is unconvincing. He recommended and undertook the elective surgery when he knew there was a contraindicating condition. He did not explain this consideration to Mrs. Gushalak. Mrs. Gushalak understood only that Dr. Isham dug around her feet and sent her home. She did not understand the surgery that was performed on her and did not understand the risks of that surgery.

3.30 Further, Mrs. Gushalak did not understand the post-operative care she required and undertook to walk about the icy Oakhill property the next day. It is clear

from her behavior at hearing that Mrs. Gushalak can follow directions. It is clear that Dr. Isham recognized a communication problem but did nothing to clarify or consult with other caregivers. Dr. Isham did not fulfill his professional obligation to inform this patient or her caregivers about the nature of the surgery she was to undergo or the risks of the surgery and its necessary post-operative care. By failing to do so, Dr. Isham misrepresented the treatment situation. He has violated RCW 18.130.180(13).

3.31 By failing to clearly communicate to Mrs. Gushalak and/or her caregivers the nature of the surgery and the necessity for appropriate post-operative care, Dr. Isham created a considerable risk that Mrs. Gushalak would be later harmed. Actual harm did occur in the form of infection and Mrs. Gushalak's fall. However, on the basis of the record herein made, the Board declines to find that the harm was the result of Dr. Isham's failure to communicate. Nonetheless, the Board finds that the unreasonable risk of harm created by Dr. Isham's negligent failure to communicate constitutes a violation of RCW 18.130.180(4).

Conclusions as to Sanction

3.32 Based on the above violations of law, the Board imposes an appropriate sanction, pursuant to RCW 18.130.160. The Board concludes that the violations are serious, in that the violations caused bodily harm or the probability of bodily harm to the patients, and thus the violations require serious sanctions. The sanctions are set forth below. In calculating the amount of the administrative fine imposed and in

consideration that the Respondent was not in violation of RCW 18.130.180(1) as ordered in the Superior Court Order Remanding and Reversing, the Board imposes a fine of $2,000 for each of the following factual violations:

a. Failing to provide patient Gadd with sufficient information to enable patient Gadd to give informed consent to the September 25, 1987 surgery, in violation of RCW 18.130.180(4) and (13). [Conclusions 3.10- 3.14]

b. Failing to provide patient Winship with accurate information about the ability to ambulate after bilateral surgery and about potential complications of bilateral surgery, in violation of RCW 18.130.180(4) and (13). [Conclusions 3.16-3.18]

c. Failing to inform patient Gushalak, or her caregivers, of the nature of the surgery performed or of post-surgical care requirements, which placed the patient at risk of infection and falls, in violation of RCW 18.130.180(4) and (13). [Conclusions 3.27- 3.31]

3.33 In calculating the amount of the administrative fine imposed, the Board imposes a fine of $5,000 for each of the following factual violations:

a. Failing to adjust patient Winship's post-surgical treatment, after clear evidence the patient had a poor surgical outcome and needed an adjustment of her treatment plan, in violation of RCW 18.13.180(4). [Conclusion 3.19]

b. Performing a second surgery on patient Winship, when the patient was still not healing properly from the first surgery performed six months before, in violation of RCW 18.130.180(4). [Conclusion 3.20]

c. Providing laser treatments on multiple occasions to patients Gadd, Winship and Mueller, in violation of RCW 18.130.180(7). [Conclusions 3.8, 3.15, 3.21, and 3.26]

IV. SECOND REVISED ORDER

Based on the foregoing Second Revised Procedural History, Second Revised Findings of Fact, and Second Revised Conclusions of Law, the Board hereby makes the following SECOND REVISED ORDER:

4.1 The license to practice podiatric medicine and surgery held by Stephen A. Isham, D.P.M., shall be and is SUSPENDED for at least five (5) years and the suspension is STAYED subject to the conditions below.

4.2 Dr. Isham shall refund all fees paid by the patient or her insurance companies for Mrs. Winship's second surgery of March 1988. He shall not be responsible for refund of any fees paid for non-surgical treatment, services, or appliances. Dr. Isham shall provide to the Board or its designee a full accounting of these fees and their reimbursement within 60 days of the effective date of this Second Revised Final Order and shall provide proof of payment within 90 days of the effective date of this Second Revised Final Order.

4.3 Dr. Isham shall pay an administrative fine of $21,000 (twenty-one thousand dollars). Half that amount shall be paid by **August 1, 2000,** and the remainder shall be paid within **one** year of the effective date of this Second Revised Final Order. The checks shall be made payable to the State Treasurer, mailed to the

Department of Health, Podiatric Medical Board, PO Box 1099, Olympia WA 98507-1099.

4.4 Dr. Isham shall complete two courses at the Podiatric Foundation in Tucker, Georgia. Each shall be of one week duration. The first course shall be completed within one year of the effective date of this Second Revised Final Order. The second shall be completed within five years of the effective date of this Second Revised Final Order.

4.5 Prior to all metatarsal osteotomies, Dr. Isham shall obtain written second opinions from a qualified practitioner approved in advance by the Board or its designee. Dr. Isham may petition in writing for relief from this requirement after six months of compliance with this requirement. At that time, all such second opinions and any requested patient records shall be made available to the Board or its designee. There shall be a hearing before the Board to consider Dr. Isham's petition and to consider any evidence presented by the Department in opposition.

4.6 Dr. Isham shall submit to the Board or its designee on a quarterly basis a list of all surgical procedures he performs. The list shall include the date the surgery was performed, an identifier for patients, and the surgical procedures performed. He shall include with the report any second opinions obtained. The reports shall be due the first day of every July, October, January, and April throughout the term of this Second Revised Final Order. Dr. Isham may petition in writing for relief from this

requirement no sooner than three years from the date of this Second Revised Final Order.

4.7 In addition to any other inspection the Department of Health may make, Dr. Isham shall permit an investigator of the Department of Health to audit records and review practice at Dr. Isham's office.

4.8 Dr. Isham shall assume all costs associated with compliance with this Second Revised Final Order.

4.9 In the event Dr. Isham leaves the practice of podiatric medicine in the state of Washington, any period of absence shall not apply to reduction of the period of suspension. Dr. Isham shall report to the Board or its designee any departure to live or practice outside the state of Washington and his return from such absences. Periodic trips of short duration for teaching shall not be considered absences for purposes of this condition.

4.10 Any failure to comply with the conditions herein imposed shall be considered grounds for additional disciplinary proceedings under RCW 18.130.180(9).

4.11 This Order is subject to the reporting requirements of RCW 18.130.110, section 1128E of the Social Security Act, and any other applicable interstate/national reporting requirements.

4.12 Within ten(10) days of the effective date of this Order, Respondent shall thoroughly complete the attached Healthcare Integrity and Proteciton Data Bank Reporting Form (Section 1128 of the Social Security Act) and return it to the

Adjudicative Clerk Office, 1107 Eastside Street, P.O. Box 47879, Olympia, WA, 98504-7879.

THE PARTIES ARE FURTHER ADVISED, pursuant to RCW 34.05.461 and 34.05.470, that within ten (10) days of service of this Second Revised Final Order you may file a petition for reconsideration with the Adjudicative Clerk Office, 1107 Eastside Street, PO Box 47879, Olympia, WA 98504-7868. The petition shall state the specific grounds upon which relief is requested. The petition for reconsideration shall not stay the effectiveness of this Second Revised Final Order. The petition is deemed to have been denied if, within twenty (20) days of the date of its filing, the Adjudicative Clerk Office has not disposed of your petition or has not served you with written notice specifying the date by which action will be taken on your petition.

"Filing" means actual receipt of the document by the Board. RCW 34.05.010(6). This Second Revised Final Order was "served" upon you on the day it was deposited in the United States mail. RCW 34.05.010(19).

Proceedings for judicial review may be instituted by filing a petition in the Superior Court in accord with the procedures specified in Chapter 34.05 RCW, Part V, Judicial Review and Civil Enforcement. The petition for judicial review must be filed within thirty (30) days after you have been served with this Revised Final Order, as provided by RCW 34.05.542.

DATED THIS 1st DAY OF FEBRUARY, 2000.

PODIATRIC MEDICAL BOARD

JOHN McCORD, D.P.M.
Panel Chair

FOR INTERNAL USE ONLY: (Internal tracking numbers)
OPS No. 94-03-01-081P
Program No. PO1022

Exhibit B
Page 21 of 27